



## MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an independent  
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# Pharmacy Medical Policy Intravenous Immunoglobulin

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## Policy Number: 310

BCBSA Reference Number: 8.01.05

## Related Policies

See medical policy #422, RSV Immunoprophylaxis (RSV-IVIg)

## Policy

### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

**Note:** All requests for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Pharmacy Operations by completing the Prior Authorization Form on the last page of this document.

This medication is covered by the pharmacy benefit. It is also covered under the Home Infusion Therapy benefit.

We cover intravenous immunoglobulin (IVIg) for the following diagnoses only:

#### Blood disorders

- Bone marrow transplant patients (for prevention of infection or GVH prevention)
- Multiple myeloma and immunoproliferative neoplasms
- Immune neutropenia
- Multiple myeloma without mention of remission
- Multiple myeloma in remission
- Other immunoproliferative neoplasms without mention of remission
- Other immunoproliferative neoplasms in remission
- Agranulocytosis
- Common variable immunodeficiency, severe combined immunodeficiency, Wiskott-Aldrich syndrome, and X-linked (X-linked Agammaglobulinemia & X-linked hyperimmunoglobulinemia M syndrome) immunodeficiency
- Fetal / Neonatal alloimmune thrombocytopenia
- Autoimmune (warm antibody) hemolytic anemia who are refractory to prednisone and splenectomy
- Agammaglobulinemia -primary humoral immunodeficiency
- Hypogammaglobulinemia -primary humoral immunodeficiency
- Chronic lymphocytic leukemia (CLL) with frequent infections and

- IgG levels are less than 400mg/dl
- Idiopathic thrombocytopenic purpura (ITP).

### **Infectious diseases**

- HIV and AIDS
- Prevention of infection in HIV-infected children and IgG levels are less than 400mg/dl
- Prior to solid organ transplant, treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients, and those receiving an ABO incompatible organ
- Solid organ transplant recipients at risk for cytomegalovirus infections and pneumonia.
- Severe Anemia associated with human parvovirus B19.
- Toxic Shock Syndrome

### **Neurologic conditions:**

- Guillain-Barré Syndrome (GBS)
- Chronic severe myasthenia gravis, for severe exacerbations causing disability
- Myasthenic crisis/exacerbations (i.e., an acute episode of respiratory muscle weakness) in patients with a contraindication to plasma exchange
- Severe refractory Myasthenia gravis in patients with chronic debilitating disease despite treatment with cholinesterase inhibitors, or complications from or failure of corticosteroids and/or azathioprine.
- Hereditary and idiopathic peripheral neuropathy
- Peroneal muscular atrophy
- Hereditary sensory neuropathy
- Idiopathic progressive polyneuropathy
- Multiple Sclerosis: for patients with relapsing-remitting disease (not primary or secondary progressive MS)
- Chronic inflammatory demyelinating polyneuropathy
- Demyelinating polyneuropathy associated with IgM paraproteinemia
- Multifocal motor neuropathy in patients with GM1 antibodies and conduction block
- Stiff-Person/Man syndrome

### **Other:**

- Dermatomyositis/polymyositis which is refractory to treatment with corticosteroids in combination with other immunosuppressive agents.
- Kawasaki syndrome
- Prior to solid organ transplant; treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients, and those receiving an ABO incompatible organ, Effective January 2007
- Following solid organ transplant; treatment of antibody-mediated rejection. Effective January 2007.
- Patients with neuromyelitis optica as an alternative for patients with contraindication or lack of response to first-line treatment particularly in children.
- Patients with severe, progressive autoimmune mucocutaneous blistering diseases that include pemphigus vulgaris (L10.0), pemphigus foliaceus (L10.2) bullous pemphigoid (L12.0) and mucous membrane pemphigoid (L12.1) who have failed treatment with conventional agents such as corticosteroids, azathioprine and cyclophosphamide.
- Ataxia telangiectasia
- Wegener's granulomatosis
- Eaton-Lambert myasthenic syndrome who have failed to respond to anticholinesterase medications and/or corticosteroids.
- Antiphospholipid syndrome
- Hemolytic disease of the fetus and newborn (aka erythroblastosis fetalis)

We do not cover intravenous immunoglobulin in the following conditions:

**Blood disorders**

- Acquired factor VIII inhibitors
- Acute lymphoblastic leukemia
- Aplastic anemia
- Diamond-Blackfan anemia
- Hemophagocytic syndrome
- Nonimmune thrombocytopenia
- Red cell aplasia
- Thrombotic thrombocytopenic purpura.

**Rheumatologic diseases**

- Behcet's syndrome
- Inclusion body myositis, because it does not work in this disorder
- Rheumatoid arthritis and other connective tissue diseases including systemic lupus erythematosus
- Scleroderma
- Systemic Lupus Erythematosus
- Other vasculitides besides Kawasaki disease; including vasculitis associated with anti-neutrophil cytoplasmic antibodies (ANCA; e.g., polyarteritis nodosa), Goodpasture's syndrome, and vasculitis associated with other connective tissue diseases.

**Neurologic conditions**

- Epilepsy
- Multiple sclerosis: primary progressive or secondary progressive types, because it has not been shown to offer additional health benefits to patients with these types of MS
- Paraneoplastic syndromes excluding Eaton-Lambert syndrome.

**Infectious**

- Chronic sinusitis
- Recurrent otitis media.

**Other**

- Adrenoleukodystrophy
- Asthma
- Chronic fatigue syndrome
- Cystic fibrosis
- Diabetes mellitus
- Hemolytic uremic syndrome
- Idiopathic lumbosacral flexopathy
- Recurrent fetal loss
- Recurrent Spontaneous Abortion
- Epidermolysis bullosa acquisita
- Recurrent spontaneous pregnancy loss
- Idiopathic environmental illness
- Myasthenia gravis in patients responsive to immunosuppressive treatment
- Post-infectious sequelae
- Organ transplant rejection
- Uveitis
- Demyelinating optic neuritis
- Recent onset dilated cardiomyopathy
- Other disorders not listed above.

**Medicare HMO Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup> Members  
Coverage Indications, Limitations, and/or Medical Necessity**

Effective October 1, 2002, IVIg is covered for the treatment of biopsy-proven (1) Pemphigus Vulgaris, (2) Pemphigus Foliaceus, (3) Bullous Pemphigoid, (4) Mucous Membrane Pemphigoid (a.k.a., Cicatricial Pemphigoid), and (5) Epidermolysis Bullosa Acquisita for the following patient subpopulations:

- Patients who have failed conventional therapy. Medicare Administrative Contractors (MACs) have the discretion to define what constitutes failure of conventional therapy;
- Patients in whom conventional therapy is otherwise contraindicated. Contractors have the discretion to define what constitutes contraindications to conventional therapy; or
- Patients with rapidly progressive disease in whom a clinical response could not be affected quickly enough using conventional agents. In such situations IVIg therapy would be given along with conventional treatment(s) and the IVIg would be used only until the conventional therapy could take effect.

In addition, IVIg for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short-term therapy and not as a maintenance therapy. Contractors have the discretion to decide what constitutes short-term therapy.

[National Coverage Determination \(NCD\) for Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases \(250.3\)](#)

#### Other Information

Blue Cross Blue Shield of Massachusetts (BCBSMA\*) members (other than Medex®; Blue MedicareRx, Medicare Advantage plans that include prescription drug coverage) will be required to fill their prescriptions for the above medications at one of the providers in our retail specialty pharmacy network, see link below:

[Link to Specialty Pharmacy List](#)

#### CPT Codes / HCPCS Codes / ICD Codes

*Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.*

*Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.*

*The following codes are included below for informational purposes only; this is not an all-inclusive list.*

**The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:**

#### HCPCS Codes

HCPCS codes:	Code Description
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial [Cytogam]
J1459	Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1556	Injection, immune globulin (Bivigam), 500 mg
J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1558	Injection, immune globulin (Xembify), 100 mg
J1559	Injection, immune globulin (Hizentra), 100 mg

J1561	Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), 500 mg [Carimune, Panglobulin ]
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), intravenous, nonlyophilized, (e.g., liquid), 500 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1575	Injection, immune globulin/hyaluronidase, (Hyqvia), 100 mg immunoglobulin
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg
J3590	Unclassified biologics (i.e. Asceniv, Cutaquig)

The following ICD Diagnosis Codes are considered medically necessary when submitted with the HCPCS codes above if medical necessity criteria are met:

### ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
A48.3	Toxic shock syndrome
B20	Human immunodeficiency virus [HIV] disease
B25.0	Cytomegaloviral pneumonitis
B25.1	Cytomegaloviral hepatitis
B25.2	Cytomegaloviral pancreatitis
B25.8	Other cytomegaloviral diseases
B25.9	Cytomegaloviral disease, unspecified
B97.6	Parvovirus as the cause of diseases classified elsewhere
C88.2	Heavy chain disease
C88.3	Immunoproliferative small intestinal disease
C88.8	Other malignant immunoproliferative diseases
C88.9	Malignant immunoproliferative disease, unspecified
C90.00	Multiple myeloma not having achieved remission
C90.01	Multiple myeloma in remission
C90.02	Multiple myeloma in relapse
C90.20	Extramedullary plasmacytoma not having achieved remission
C90.21	Extramedullary plasmacytoma in remission
C90.22	Extramedullary plasmacytoma in relapse
C90.30	Solitary plasmacytoma not having achieved remission
C90.31	Solitary plasmacytoma in remission
C90.32	Solitary plasmacytoma in relapse
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.11	Chronic lymphocytic leukemia of B-cell type in remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
D59.0	Drug-induced autoimmune hemolytic anemia
D59.10	Autoimmune hemolytic anemia, unspecified
D59.11	Warm autoimmune hemolytic anemia
D59.12	Cold autoimmune hemolytic anemia
D59.13	Mixed type autoimmune hemolytic anemia
D59.19	Other autoimmune hemolytic anemia

D61.2	Aplastic anemia due to other external agents
D68.61	Antiphospholipid syndrome
D69.3	Immune thrombocytopenic purpura
D69.41	Evans syndrome
D69.42	Congenital and hereditary thrombocytopenia purpura
D69.49	Other primary thrombocytopenia
D69.6	Thrombocytopenia, unspecified
D70.8	Other neutropenia
D80.0	Hereditary hypogammaglobulinemia
D80.1	Nonfamilial hypogammaglobulinemia
D80.2	Selective deficiency of immunoglobulin A [IgA]
D80.3	Selective deficiency of immunoglobulin G [IgG] subclasses
D80.4	Selective deficiency of immunoglobulin M [IgM]
D80.5	Immunodeficiency with increased immunoglobulin M [IgM]
D81.0	Severe combined immunodeficiency [SCID] with reticular dysgenesis
D81.1	Severe combined immunodeficiency [SCID] with low T- and B-cell numbers
D81.2	Severe combined immunodeficiency [SCID] with low or normal B-cell numbers
D81.6	Major histocompatibility complex class I deficiency
D81.7	Major histocompatibility complex class II deficiency
D81.89	Other combined immunodeficiencies
D81.9	Combined immunodeficiency, unspecified
D82.0	Wiskott-Aldrich syndrome
D83.0	Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function
D83.2	Common variable immunodeficiency with autoantibodies to B- or T-cells
D83.8	Other common variable immunodeficiencies
D83.9	Common variable immunodeficiency, unspecified
D84.81	Immunodeficiency due to conditions classified elsewhere
D84.821	Immunodeficiency due to drugs
D84.822	Immunodeficiency due to external causes
D84.89	Other immunodeficiencies
D84.9	Immunodeficiency, unspecified
D89.82	Autoimmune lymphoproliferative syndrome [ALPS]
G11.3	Cerebellar ataxia with defective DNA repair
G25.82	Stiff-man syndrome
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G60.0	Hereditary motor and sensory neuropathy
G60.2	Neuropathy in association with hereditary ataxia
G60.3	Idiopathic progressive neuropathy
G60.8	Other hereditary and idiopathic neuropathies
G60.9	Hereditary and idiopathic neuropathy, unspecified
G61.0	Guillain-Barre syndrome
G61.81	Chronic inflammatory demyelinating polyneuritis
G61.89	Other inflammatory polyneuropathies
G62.89	Other specified polyneuropathies
G64	Other disorders of peripheral nervous system
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation
G70.80	Lambert-Eaton syndrome in disease classified elsewhere
L10.0	Pemphigus vulgaris

L10.1	Pemphigus vegetans
L10.2	Pemphigus foliaceus
L10.3	Brazilian pemphigus [fogo selvagem]
L10.4	Pemphigus erythematous
L10.5	Drug-induced pemphigus
L10.81	Paraneoplastic pemphigus
L10.89	Other pemphigus
L10.9	Pemphigus, unspecified
L12.0	Bullous pemphigoid
L12.1	Cicatricial pemphigoid
L12.8	Other pemphigoid
L12.9	Pemphigoid, unspecified
M30.3	Mucocutaneous lymph node syndrome [Kawasaki]
M31.30	Wegener's granulomatosis without renal involvement
M31.31	Wegener's granulomatosis with renal involvement
M33.00	Juvenile dermatomyositis, organ involvement unspecified
M33.01	Juvenile dermatomyositis with respiratory involvement
M33.02	Juvenile dermatomyositis with myopathy
M33.09	Juvenile dermatomyositis with other organ involvement
M33.10	Other dermatomyositis, organ involvement unspecified
M33.11	Other dermatomyositis with respiratory involvement
M33.12	Other dermatomyositis with myopathy
M33.19	Other dermatomyositis with other organ involvement
M33.20	Polymyositis, organ involvement unspecified
M33.21	Polymyositis with respiratory involvement
M33.22	Polymyositis with myopathy
M33.29	Polymyositis with other organ involvement
M33.90	Dermatopolymyositis, unspecified, organ involvement unspecified
M33.91	Dermatopolymyositis, unspecified with respiratory involvement
M33.92	Dermatopolymyositis, unspecified with myopathy
M33.99	Dermatopolymyositis, unspecified with other organ involvement
M36.0	Dermato(poly)myositis in neoplastic disease
P55.0	Rh isoimmunization of newborn
P55.1	ABO isoimmunization of newborn
P55.8	Other hemolytic diseases of newborn
P55.9	Hemolytic disease of newborn, unspecified
P61.0	Transient neonatal thrombocytopenia
R75	Inconclusive laboratory evidence of human immunodeficiency virus [HIV]
T86.00	Unspecified complication of bone marrow transplant
T86.01	Bone marrow transplant rejection
T86.03	Bone marrow transplant infection
T86.09	Other complications of bone marrow transplant
T86.10	Unspecified complication of kidney transplant
T86.11	Kidney transplant rejection
T86.13	Kidney transplant infection
T86.19	Other complication of kidney transplant
T86.20	Unspecified complication of heart transplant
T86.21	Heart transplant rejection
T86.23	Heart transplant infection
T86.290	Cardiac allograft vasculopathy
T86.298	Other complications of heart transplant

T86.30	Unspecified complication of heart-lung transplant
T86.31	Heart-lung transplant rejection
T86.33	Heart-lung transplant infection
T86.39	Other complications of heart-lung transplant
T86.40	Unspecified complication of liver transplant
T86.41	Liver transplant rejection
T86.43	Liver transplant infection
T86.49	Other complications of liver transplant
T86.5	Complications of stem cell transplant
T86.810	Lung transplant rejection
T86.812	Lung transplant infection
T86.818	Other complications of lung transplant
T86.819	Unspecified complication of lung transplant
T86.90	Unspecified complication of unspecified transplanted organ and tissue
T86.91	Unspecified transplanted organ and tissue rejection
T86.93	Unspecified transplanted organ and tissue infection
T86.99	Other complications of unspecified transplanted organ and tissue
Z48.290	Encounter for aftercare following bone marrow transplant
Z94.81	Bone marrow transplant status

#### Other Information

##### Preferred Home Infusion Therapy Network

Referring providers are encouraged to use these preferred Home Infusion providers to obtain these medications.

#### Preferred Home Infusion Therapy Provider Contact Information:

Accredo Health Group

Phone: 1-877-988-0058

Website: [www.accredo.com](http://www.accredo.com)

Caremark, LLC.

Phone: 1-866-846-3096

Website: [www.caremark.com](http://www.caremark.com)

Coram™ Specialty Infusion Services

Phone: 1-800-678-3442

Website: [www.coramhc.com](http://www.coramhc.com)

Home Solutions

Falmouth Location:

Phone: 1-508-548-4266 or toll free 1-800-244-1227

Canton Location:

Phone: 1-617-989-0888 or toll free at 1-888-660-1660

Website: [www.infusionreferral.com](http://www.infusionreferral.com)

#### Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts  
Pharmacy Operations Department  
25 Technology Place



Hingham, MA 02043  
 Tel: 1-800-366-7778  
 Fax: 1-800-583-6289

### Managed Care Authorization Instructions

- Prior authorization is required for all out patient sites of service
- For all outpatient sites of service requesting retail pharmacy exceptions, physicians may fax or mail the attached form to the address above

### PPO and Indemnity Authorization Instructions

- Prior authorization **is** required when this medication is processed under the home infusion therapy benefit.
- Prior authorization **is not** required when drugs are not part of Pharmacy only program and is purchased by the physician and administered in the office in accordance with this medical policy.
- Physicians may also fax or mail the attached form for retail pharmacy exceptions to the address above.

### Policy History

Date	Action
12/2020	BCBSA National medical policy review. No changes to policy statements. New references added.
10/2020	Clarified coding information
4/2020	Updated to add Asceniv to the policy.
11/2019	Updated to add Xembify to the policy.
7/2019	Updated to add Cutaquig to the policy.
1/2019	Clarified coding information.
8/2018	Updated to include Association coverage statement for Neuromyelitis Optica & Blistering disease.
10/2017	Clarified coding information plus updated to change Walgreens Specialty Name.
7/2017	Updated to add AllCare to Pharmacy Specialty list.
6/2017	Updated address for Pharmacy Operations.
1/2016	Updated to add new HCPCS code J1575.
10/2015	Updated to included revised language for Pharmacy only medications.
7/2015	Update to include Retail billing.
6/2015	Updated to include Bivigam, Cytogam, Gammplex, Hizentra and HyQvia and to align ICD codes.
2/2015	Updated to include a couple HCPCS codes and one ICD code.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
1/2014	Updated ExpressPAth Language.
1/2013	Updated 1/2013 to include new FDA products Gammaked™ and Gamunex®-C.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2012	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
11/2011	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
10/2011	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2011	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.

1/2011	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
12/2010	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
10/2010	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
1/2010	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
12/2009	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
11/2009	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
10/2009	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
9/2009	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
10/2009	Updated to reflect UM requirements.
1/2009	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
12/2008	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
11/2008	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
10/2008	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
10/2008	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
1/2008	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
9/2007	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
1/2007	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.

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## Endnotes

1. Revised 9/95 based on TEC (Technology Evaluation Center) 6/95 assessment of medical literature from 1991 to 1995 addressing IVIg for SLE-related cytopenia, vasculitis, pericarditis, and pleural effusions in patients who were not controlled by immunosuppressives or cytotoxic agents.
2. Revised 9/95 to include the 2/95 TEC evaluation of medical literature from 1991-4/95 assessing IVIg to improve the functional status of patients with inclusion body myositis who have not responded to prednisone or other immunosuppressives.
3. Revised 10/95 based on 1994 TEC evaluation of medical literature from 1991-1994 assessing IVIG to stop progression of muscle weakness or to decrease frequency or severity of relapses in MS..
4. Revised 10/95 based on a 1994 TEC evaluation of medical literature from 1991-1994 assessing IVIg to improve functional capacity or to reduce pain in patients with RA refractory to NSAIDs and either cytotoxic or disease-modifying antirheumatic drugs.
5. Revised 10/95 based on a 1994 TEC evaluation of medical literature from 1991-1994 assessing IVIG to improve neurologic function in CIDP, either as first-line therapy, or for acute exacerbations in patients refractory or intolerant of prednisone or azathioprine.
6. Revised 10/95 based on a 1994 TEC evaluation of medical literature assessing IVIG to reduce fetal loss in women with recurrent fetal loss (sequence of 3 or more miscarriages), with or without antiphospholipid antibodies.
7. Revised 3/96 to include CMS (Centers for Medicare and Medicaid services) regulations published in the February/March 1996 issue of the Medicare Health Resources.
8. Revised 2/97 to include CMS (Centers for Medicare and Medicaid services) regulations published in the February/March 1997 issue of the Medicare Health Resources.
9. Revised 9/97 to include CMS regulations (Centers for Medicare and Medicaid services) published in the June/July 1997 Medicare B Health Resources.
10. Added based on recommendations made by the Massachusetts Neurological Society.
11. Based on the July 1998 TEC (Technology Evaluation Center) analysis of the literature on IVIg for MS. Health outcomes considered by TEC included prevention of disease progress and disability, improving baseline neuro disability, and reducing acute relapse. Also see the July/August 1997 ACP Journal Club commentary: <http://www.acponline.org/journals/acpjc/julaug97> Regarding the article: Fazekas F et al., Austrian Immunoglobulin in Multiple Sclerosis Study Group. Randomized placebo-controlled trial of monthly intravenous immunoglobulin therapy in relapsing-remitting multiple sclerosis. *Lancet.* 1997 Mar 1;349:589-93.
12. FDA-approved uses as of July, 1998.

13. Off-label use in the treatment of AIDS and HIV as required by law.
14. Label use based on National Blue Cross Blue Shield policy 8.01.05, issued 12/15/98.
15. Off-label use based on National Blue Cross Blue Shield policy 8.01.05, issued 12/15/98.
16. Investigational use based on National Blue Cross Blue Shield policy 8.01.05, issued 12/15/98.
17. Based on recommendations from Walt Kagan, MD, Massachusetts Society of Clinical Oncologists.
18. Based upon a September 1999 Medicare B HealthResource Newsletter.
19. Medicare policy is developed separately from BCBSMA policy. While BCBSMA policy is based upon scientific evidence, Medicare policy incorporates scientific evidence with local expert opinion, and governmental regulations from CMS (Centers for Medicare and Medicaid Services) and the U.S Congress. While BCBSMA and Medicare policies may differ, our Medicare HMO Blue and Medicare PPO Blue members must be offered the same services as Medicare offers. In many instances, BCBSMA policies offer more benefits than does Medicare policy.
20. Based on recommendations from David Weinberg, MD, Massachusetts Neurologic Association, 1/2000 MPG Neurology meeting.
21. Medical Policy Group, August 2000.
22. Previous criteria summarized in the current form: vital capacity less than 1L; dysphagia associated with aspiration; inability to ambulate 100 feet without assistance.
23. Medical Policy Group, January 2000.
24. Idiopathic Thrombocytopenic Purpura: A Practice Guideline Developed by Explicit Methods for the American Society of Hematology
25. See the 1998 ASRM (American Society of Reproductive Medicine) Practice Committee Report on Intravenous Immunoglobulin and Spontaneous Pregnancy Loss.
26. Based on the June 2002 Medicare B Resource Newsletter. See also the CMS /Medicare websites at [www.cms.gov](http://www.cms.gov) and [www.medicare.gov](http://www.medicare.gov).
27. Based upon the 2002 Blue Cross Blue Shield Association policy 8.01.05. IVIG for myasthenic crisis is considered medically necessary. Myasthenic crisis is an off-label indication.
28. Based upon the 2002 Blue Cross Blue Shield Association National policy 8.01.05.
29. Based upon the 2004 Blue Cross Blue Shield Association policy 2.01.01.
30. Based upon the 2004 Blue Cross Blue Shield Association National policy 8.01.05.
31. Consensus statement on the use of intravenous immunoglobulin therapy in the treatment of autoimmune mucocutaneous blistering diseases. Arch Dermatol.2003;139:1051-1059.
32. Based upon the 2004 BCBSA National Policy 8.01.05. Bone marrow transplant patients (for prevention of infection or GVH prevention.)
  - Cordonnier C, Chevret S, Legrand M et al. Should immunoglobulin therapy be used in allogeneic stem-cell transplantation? A randomized, double-blind, dose effect, placebo-controlled multicenter trial. Ann Intern Med 2003;139(1):8-18.
33. Based upon the 2004 BCBSA National Policy 8.01.05. Recurrent Spontaneous Abortion.
34. Based on Blue Cross Blue Shield National policy 8.01.05 Intravenous Immune Globulin Therapy issued 4/06.

**To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:**

<http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf>

**Home Infusion Therapy**  
Prior Authorization Form



Please complete and fax with the physician's prescription to: (888) 641-5355. If the patient is a BCBSMA employee, please fax the form to: (617)246-4013.

Company name:		Contact Name:	
Phone #:		Provider #:	
Fax#		Address:	
Patient name:		Address:	
Patient_ID#:		DOB: ___/___/___	Diagnosis:
Prescribing Physician/addr:	_____		Telephone:
PCP name/address:	_____		Telephone:

Is this fax number 'secure' for PHI receipt/transmission per HIPAA requirements? (circle one) Yes No

Place of Service  Home  SNF  MD office  other (specify) \_\_\_\_\_

Primary Therapy

Primary drug name: \_\_\_\_\_ Approximate duration: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_ Route of Administration: \_\_\_\_\_ pump: Y N

Other Therapy

Other drug name: \_\_\_\_\_ Approximate duration: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_ Route of Administration: \_\_\_\_\_ pump: Y N

If this is a "drug only" authorization request, indicate other services the nursing agency is providing:

Nursing provided by: \_\_\_\_\_ Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Request for 7 Day Coverage : Date of occurrence: \_\_\_\_\_ request dates: \_\_\_\_\_

Occurrence type:  Hospitalization  Death  Change of Therapy

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OR Copy of prescription REQUIRED with this request**