Immune Globulin (IVIG and SCIG) (for Ohio Only)

Policy Number: CSOH2025D0035.C
Effective Date: May 1, 2025

➲ Instructions for Use

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Related Policies

None

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

This policy refers to FDA-approved intravenous (IV) and subcutaneous (SC) immune globulin (IG) products including but not limited to the following (list not all inclusive):

- Alyglo™ (IV)
- Asceniv™ (IV)
- Bivigam® (IV)
- Cutaquig® (SC)
- Cuvitru® (SC)
- Flebogamma® DIF (IV)
- Gammagard® Liquid (IV, SC)
- Gammagard® S/D (IV)
- Gammaked™ (IV, SC)
- Gammaplex® (IV)
- Gamunex®-C (IV, SC)
- Hizentra® (SC)
- HyQvia® (SC)
- Octagam® (IV)
- Panzyga® (IV)
- Privigen® (IV)
- Xembify® (SC)
- Yimmugo® (IV)

Medical Necessity Criteria

For medical necessity clinical coverage criteria, refer to the current InterQual® guideline for:

- **Asceniv**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG)(Asceniv)
- **Bivigam**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) (Bivigam)
- **Cutaquig**: CP: Specialty Rx Non-Oncology, Immune globulin, subcutaneous (SCIG)(Cutaquig)
- **Cuvitru**: CP: Specialty Rx Non-Oncology, Immune globulin, subcutaneous (SCIG)(Cuvitru)
- **Flebogamma DIF**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous immunoglobulin (IVIG) (Flebogamma 10% DIF/Flebogamma 5% DIF)
- **Gammagard Liquid**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) or subcutaneous (SCIG) (Gammagard liquid)
- **Gammagard S/D**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) (Gammagard S/D)
- **Gammaked**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) or subcutaneous (SCIG) (Gammaked)
- **Gammaplex**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) (Gammaplex 10%/5%)
- **Gamunex-C**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) or subcutaneous (SCIG) (Gamunex-C)
- **Hizentra**: CP: Specialty Rx Non-Oncology, Immune globulin, subcutaneous (SCIG) (Hizentra)
- **HyQvia**: CP: Specialty Rx Non-Oncology, Immune globulin, subcutaneous (SCIG) (HyQvia)
- **Octagam**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) (Octagam 10%/5%)
- **Panzyga**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) (Panzyga)

- **Privigen**: CP: Specialty Rx Non-Oncology, Immune globulin, intravenous (IVIG) (Privigen)
- **Xembify**: CP: Specialty Rx Non-Oncology, Immune globulin, subcutaneous (SCIG) (Xembify)

Click here to view the InterQual® criteria.

In absence of a product listed, and in addition to applicable criteria outlined within the drug policy, prescribing and dosing information from the package insert is the clinical information used to determine benefit coverage.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
90283	Immune globulin (IgIV), human, for intravenous use
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each

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HCPCS Code	Description
J1459	Injection, immune globulin (Privigen®), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1551	Injection, immune globulin (Cutaquig), 100 mg
J1552	Injection, immune globulin (Alyglo), 500 mg
J1554	Injection, immune globulin (Asceniv™), 500 mg
J1555	Injection, immune globulin (Cuvitru®), 100 mg
J1556	Injection, immune globulin (Bivigam®), 500 mg
J1557	Injection, immune globulin, (Gammaplex®), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1558	Injection, immune globulin (Xembify®), 100 mg
J1559	Injection, immune globulin (Hizentra®), 100 mg
J1561	Injection, immune globulin, (Gamunex®-C/Gammaked™), intravenous, nonlyophilized (e.g., liquid), 500 mg
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
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 immune globulin
J1576	Injection, immune globulin (Panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg

Policy History/Revision Information

Date	Summary of Changes

05/01/2025	**Coverage Rationale**
	• Revised list of applicable FDA-approved intravenous (IV) and subcutaneous (SC) immune globulin (IG) products; added:
	  ○ Alyglo™ (IV)
	  ○ Yimmugo® (IV)

Date	Summary of Changes
	• Added language to indicate, in absence of a product listed [in the policy], and in addition to applicable criteria outlined within the policy, prescribing and dosing information from the package insert is the clinical information used to determine benefit coverage **Applicable Codes** • Added HCPCS codes J1552 and J1576 **Supporting Information** • Archived previous policy version CSOH2024D0035.B

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]), or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.