Reference number
5766-A

JURISDICTION SPECIFIC MEDICARE PART B

Subcutaneous Immune Globulin (SCIG):
Cutaquig, Cuvitru, Hizentra, Hyqvia, Xembify

POLICY

I. COVERED USES

The indications below are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. Cutaquig, Cuvitru, Xembify
   1. Primary humoral immunodeficiency (e.g., common variable immunodeficiency, congenital agammaglobulinemia, severe combined immunodeficiency, X-linked immunodeficiency hyperimmunoglobulin M, Wiskott-Aldrich syndrome)

B. Hizentra, Hyqvia
   1. Primary humoral immunodeficiency (e.g., common variable immunodeficiency, congenital agammaglobulinemia, severe combined immunodeficiency, X-linked immunodeficiency hyperimmunoglobulin M, Wiskott-Aldrich syndrome)
   2. Chronic inflammatory demyelinating polyneuropathy (CIDP)

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. CRITERIA FOR APPROVAL

A. Cutaquig, Cuvitru, Xembify

1. Primary humoral immunodeficiency
Authorization of 6 months may be granted for the treatment of primary humoral immunodeficiency.

B. Hizentra, Hyqvia

1. Primary humoral immunodeficiency
Authorization of 6 months may be granted for the treatment of primary humoral immunodeficiency.

2. Chronic inflammatory demyelinating polyneuropathy (CIDP)
Authorization of 6 months may be granted for the treatment of chronic inflammatory demyelinating polyneuropathy.

III. REFERENCES

1. Immune Globulin (IVIG) LCD (L35093) Version R18. Available at: https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Accessed March 12, 2024.

2. Billing and Coding: Immune Globulin (IVIG) (A56786) Version R10. Available at: https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Accessed March 12, 2024.

