

Reference number(s)
6187-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	<input type="checkbox"/>
Standard Control Choice (SCCF)	<input type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input type="checkbox"/>
Advanced Control Specialty Choice (ACSCF)	<input type="checkbox"/>
Managed Medicaid Template (MMT)	<input type="checkbox"/>
Marketplace (MF)	<input type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	<input type="checkbox"/>
Value (VF)	<input type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSFC)	<input type="checkbox"/>
Value Formulary Chart (VFC)	<input type="checkbox"/>
Medical Benefit	<input type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Combined Benefit Management (CBM)	<input type="checkbox"/>
Combined Benefit Management Pharmacy (CBMP)	<input type="checkbox"/>
Medical Benefit Managed Medicaid (MMMB)	<input checked="" type="checkbox"/>

Exceptions Criteria

Subcutaneous Immune Globulins

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Medical Benefit Managed Medicaid (MMMB).

Plan Design Summary

This program applies to the subcutaneous immune globulin products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Subcutaneous Immune Globulin Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	<ul style="list-style-type: none"> • Hizentra • Xembify

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	Product(s)
Target	<ul style="list-style-type: none"> • Cutaquig • Cuvitru • HyQvia

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for a targeted product is provided when the member has a documented inadequate response or intolerable adverse event with both of the preferred products.

References

1. Cutaquig [package insert]. Hoboken, NJ: Octapharma USA Inc.; November 2021.
2. Cuvitru [package insert]. Lexington, MA: Baxalta US Inc.; February 2025.
3. Hizentra [package insert]. Kankakee, IL: CSL Behring LLC; April 2023.
4. HyQvia [package insert]. Lexington, MA: Baxalta US Inc.; July 2025.
5. Xembify [package insert]. Research Triangle Park, NC: Grifols Therapeutics LLC; July 2024.