DOCUMENT REVISION HISTORY LOG

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MEMORIAL HERMANN HEALTH PLAN HOLDINGS, LLC
POLICY

POLICY TITLE: MHHP MEDM-MA IGG-006 Immune Globulin Step Therapy Criteria

PUBLICATION DATE: 06/02/2025
LAST REVIEW DATE: 06/02/2025
VERSION: 2

Version	*Change Summary*	*Revised By*
1	Legacy document; Approved by P&T Committee 5/7/2025	D. Pierce/S. Soman
2	Type o in the policy statement corrected; Related document title corrected	D. Pierce

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POLICY PURPOSE:

The Memorial Hermann Health Plan Immune Globulins Step Therapy Criteria policy aims to advise providers of preferred drug products and outline the exceptions to preferred drug products during the prior authorization process. Step therapy criteria is applied in conjunction with any relevant National Coverage Determinations (NCD), Local Coverage Determination (LCD), InterQual and other MHHP internal medical necessity and or Part B drug criteria.

DEFINITIONS:

None

SCOPE:

This policy applies to Memorial Hermann Medicare plans.

POLICY STATEMENT

The step therapy program applies to immune globulin products as described in this policy. Requested Part B drug coverage must comply with step criteria in this policy. If approved, authorizations will be approved for 6 months. If a provider administers a non-preferred drug without obtaining prior authorization, the request for coverage may be denied. Preferred drugs may still require prior authorization as the review process is where medical necessity and whether any exceptions to the preferred drug is determined. This policy applies to all Medicare members who are new to treatment with a non-preferred drug. A member will not be required to change the current drug treatment. For the purposes of this policy, "current drug treatment" is defined as either a paid claim for the drug or clinical documentation confirming that the member has been using the non-preferred drug within the past 365 days. In addition, there must be

evidence of regular follow-up visits with the prescribing physician within the last 6 months. The member must also demonstrate clinical improvement as a result of the ongoing treatment. If a new plan member is currently using a particular drug, MHHP will not require the member to switch to the preferred drug upon enrollment. An existing member currently using a particular drug will not be required to change drug/products if this policy is updated. Not all indications for the non-preferred drug are listed in this policy. Indications and medications listed in this policy may change upon varying factors and should be evaluated by guidelines, the FDA and manufacturer package insert to verify appropriate use at the time of review.

IVIG - Immune Globulins for Intravenous administration

Initial (New Starts) Authorization Criteria
Preferred drug (s): Gammaked Gamunex-C Octagam Privigen
Non-preferred drug(s): Alyglo Gammagard Liquid Asceniv Gammagard S/D Bivigam Gammaplex Flebogamma Panzyga Yimmugo (Note: Any drugs not listed as preferred will be considered non-preferred until the next policy update)
Criteria: Coverage for the non-preferred drugs (s) is provided when there is clinical documentation to support one or more of the following criteria: **1.** The member has received the requested non-preferred drugs in the past 365 days and there is objective evidence of clinical benefit via imaging, lab results, or clinical assessment **OR** 2. There has been an inadequate response to the preferred drug (s) **OR** 3. There has been an adverse event related to the preferred drug(s) **OR** 4. There is a contraindication to the preferred drugs **AND** 5. Dosing must be in accordance with FDA approved labeling or otherwise supported by approved compendia and disease specific treatment guidelines.

Related documents

MHHP MEDM-MA 303 Medical Necessity Determinations

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