

HealthAlliance**MEDICARE**

PURPOSE OF THE POLICY

To establish guidelines for coverage of Vivaglobin®.

STATEMENT OF THE POLICY

Vivaglobin® and Hizentra will be covered when the following criteria are met, and applies to new starts only for Medicare Part D Members.

PROCEDURES

1. Criteria

- 1.1 FDA approved indications under Part D.
- 1.2 Three (3) month approval at a time.

2. Exclusions

- 2.1 Not to be given in conditions such as ITP and Neuropathies in which large doses are usually given to block FC Receptor function, complement deposition or other immunomodulatory effects.

3. References

- 3.1 Use of immune globulin in primary immunodeficiency; 2007 UpToDate
- 3.2 Vivaglobin [product labeling]. CSLBehring, January 2006.
- 3.3 Hizentra (product labeling). CSL Behring, 2010