This guideline addresses the criteria for consideration of allowing hospital outpatient facility infusion services for intravenous Immune Globulin (IVIG) and subcutaneous Immune Globulin (SCIG) therapy. This includes hospital based services with the following CMS/AMA Place of Service (POS) codes:

- 19 (Off Campus-Outpatient Hospital); and
- 22 (On Campus-Outpatient Hospital)

Alternative Sites of Care, such as non-hospital outpatient infusion, physician office, ambulatory infusion suites, or home infusion services are well accepted places of service for medication infusion therapy. If an individual does not meet criteria for outpatient hospital facility infusion, alternative Sites of Care may be used.

Clinical use of Immune Globulin is proven and medically necessary, in accordance with the UnitedHealthcare Medical Benefit Drug Policy titled Immune Globulin (IVIG and SCIG).

Outpatient hospital facility-based Immune Globulin infusion is medically necessary for individuals who meet at least ONE of the following criteria (submission of medical records is required):

1. Documentation that the individual is medically unstable for administration of Immune Globulin at the alternative Sites of Care as determined by any of the following:
   a. The individual’s complex medical status or therapy requires enhanced monitoring and potential intervention above and beyond the capabilities of the office or home infusion setting; or
   b. The individual’s documented history of a significant comorbidity (e.g., cardiopulmonary disorder) or fluid overload status that precludes treatment at an alternative Site of Care; or
   c. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment; or
   d. Difficulty establishing and maintaining patent vascular access; or
   e. To initiate, re-initiate, or change Immune Globulin products for a short duration (e.g., 4 weeks); or
2. Documentation (e.g., infusion records, medical records) of episodes of severe or potentially life-threatening adverse events (e.g., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other pre-medications, thereby increasing risk to the individual when administration is in the home or office setting; or
3. Initial infusion, change of Immune Globulin product, or re-initiation of therapy after more than 6 months; or
4. Individual has immunoglobulin A (IgA) deficiency with anti-IgA antibodies; or
5. Homecare or infusion provider has deemed that the individual, home caregiver, or home environment is not suitable for home infusion therapy (if the prescriber cannot infuse in the office setting).
Ongoing outpatient hospital facility-based infusion duration of therapy will be no more than 6 months to allow for reassessment of the individual’s ability to receive therapy at an alternative Site of Care.

**Note:** If more than one of the above criteria are met, then the greatest of the applicable approval time periods will be allowed.

### DEFINITIONS

**Immune Globulin:** Immune Globulins are components of the immune system. There are several types of Immune Globulin produced by the body (e.g., IgA, IgD, IgE, IgG, IgM). This policy addresses therapeutic use Immune Globulin G (IgG) an antibody produced by the B lymphocytes. References to Immune Globulin within this guideline refer to IgG. IgG products have been referred to in multiple ways, some of which are: Immune Globulin (IG), immunoglobulin, gamma globulin, and also by its route of administration - intravenous Immune Globulin (IVIG), Immune Globulin intravenous (IGIV), subcutaneous Immune Globulin (SCIG), Immune Globulin subcutaneous (IGSC).

**Site of Care:** Choice for physical location of infusion administration. Sites of Care include hospital inpatient, hospital outpatient, community office, ambulatory infusion suite, or home-based setting.

### BENEFIT CONSIDERATIONS

This guideline applies to UnitedHealthcare Commercial plan members who have medical necessity language in their Certificate of Coverage (COC) or Summary Plan Document with benefits available for health care services if medically necessary and have been approved for the requested medication clinical use. The guideline does not apply to Medicare or Medicaid plans.

### CLINICAL EVIDENCE

Immune globulin infusion is administered in various sites of care. The Immune Deficiency Foundation surveyed 1,030 patients on where they were treated with immune globulin. Twenty-six percent usually received infusions at a hospital outpatient department (21%) or at a hospital clinic (5%). Other sites reported included a doctor’s private office (9%) or an infusion suite (16%). The most common site was in the home (42%), most commonly administered by a nursing professional (2008).

Infusion in the home (POS 12) is well established and accepted by physicians. A survey of home infusion providers by the National Home Infusion Association reported 1.24 million therapies had been provided to approximately 829,000 patients, including 129,071 infusion therapies of specialty medications including immune globulin (2010).

**Professional Societies**

**American Academy of Allergy Asthma and Immunology (AAAAI)**

AAAAI treatment guidelines provide several site of care options for administering immune globulin, with the appropriate option being based on the patient’s clinical condition (2011):

- Hospital inpatient physician/nurse supervised infusion
- Hospital outpatient physician/nurse supervised infusion
- Physician office based physician/nurse supervised infusion
- Home based infusion with nurse supervision
- Home based infusion without nurse supervision

### REFERENCES


GUIDELINE HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>05/01/2019</td>
<td>• Changed policy title; previously titled Immune Globulin Site of Care Review Guidelines for Medical Necessity of Hospital Outpatient Facility Infusion</td>
</tr>
<tr>
<td></td>
<td>• Simplified coverage rationale (no change to guidelines)</td>
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<td></td>
<td>• Archived previous policy version URG-10.04</td>
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INSTRUCTIONS FOR USE

This Utilization Review Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Utilization Review Guidelines 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.