Intravenous Immune Globulin Therapy

Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.

Prospective review is not required.

**Description:**
Intravenous immune globulin (IVIg) is defined as an approved plasma derivative for the treatment of primary immune deficiency disease. IVIg has been used to correct immune deficiencies in patients with either inherited or acquired immunodeficiencies and has also been investigated as an immunomodulator in diseases thought to have an autoimmune basis.

**Medical Criteria:**
Not applicable for a reimbursement policy:

**Policy:**
IVIg is covered.

**Coverage:**
Benefits may vary between groups/contracts. Please refer to the appropriate member certificate/subscriber agreement/Rite Care contract for applicable infusion benefits/coverage.

Note: This medication is **not** available in the pharmacy.

**Specialty Pharmacy:**
For contracts with specialty drug coverage, please refer to the member agreement for benefits and preauthorizations guidelines.

**Coding:**
90283
C9270 Effective 12/31/11 code deleted
J1557
J1566

**Also Known As:**
Gamimmune N
Gammagard S/D
Gammar-P I.V.
Gamunex
Iveegam
Panglobulin
Polygam
Polygam S/D
Sandoglobulin
Venoglobulin-I
Venoglobulin-S

Related Topics:
Not applicable

Published
Policy Update, September 2000
Policy Update, January 2005
Policy Update, January 2006
Policy Update, January 2007
Policy Update, January 2008
Provider Update, December 2008

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