

Intravenous Immune Globulins (Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen, Yimmugo)

When requesting Intravenous Immune Globulins (Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen, Yimmugo), the individual requiring treatment must be diagnosed with one of the following FDA-approved indications or approved off-label compendial uses and meet the specific coverage guidelines and applicable safety criteria for the covered indication.

FDA-approved Indications

Intravenous Immune globulin (IVIG) injection is indicated for the treatment of:

- Primary humoral immunodeficiency including but not limited to: congenital agammaglobulinemia, common variable immunodeficiency, x-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies
- Idiopathic thrombocytopenia purpura (ITP) to raise platelet counts to prevent bleeding or to allow a patient with ITP to undergo surgery
- Chronic inflammatory demyelinating polyneuropathy (CIDP) to improve neuromuscular disability and impairment and for maintenance therapy to prevent relapse
- Multifocal motor neuropathy (MMN) to improve muscle strength and disability
- Prevention of bacterial infections in hypogammaglobulinemia and/or recurrent bacterial infections associated with B-cell chronic lymphocytic leukemia
- Prevention of coronary artery aneurysms associated with Kawasaki syndrome
- Dermatomyositis or polymyositis

Approved Off-label Compendial Uses

- Secondary humoral immunodeficiency
- Antibody-mediated rejection in solid organ transplant
- Autoimmune mucocutaneous blistering disease
- Cytomegalovirus (CMV) interstitial pneumonia
- Guillain-Barre syndrome
- Human immunodeficiency virus (HIV) associated thrombocytopenia
- Hepatitis C associated thrombocytopenia
- Treatment or post-exposure prophylaxis for tetanus
- Myasthenia gravis

- Lambert-Eaton myasthenic syndrome
- Multiple sclerosis
- Stiff-person syndrome
- Multiple myeloma
- Pure red blood cell aplasia (PRCA)
- Post-exposure prophylaxis of measles
- Post-exposure prophylaxis of varicella
- Feto-neonatal alloimmune thrombocytopenia
- For desensitization therapy prior to and immediately after solid organ transplantation
- Immunotherapy-related toxicities associated with checkpoint inhibitor therapy
- Myelin Oligodendrocyte Glycoprotein Antibody-Associated Disease (MOGAD)
- Immune-Mediated Necrotizing Myopathy
- Aquaporin-4 Immunoglobulin Antibodies (AQP4-IgG)-Positive Neuromyelitis Optica Spectrum Disorder (NMOSD)

Coverage Guidelines

Primary Humoral Immunodeficiency (PI)

The individual must meet the following criteria for initial authorization:

- Must have one of the following PI subtypes:
 - o Common variable immunodeficiency (CVID)
 - o X-linked agammaglobulinemia
 - o Congenital agammaglobulinemia
 - o Other agammaglobulinemia due to the absence of B-cells
 - o Severe combined immunodeficiency (SCID)
 - o Wiskott-Aldrich syndrome
 - o Hyper-Immunoglobulin M (IgM) syndromes
 - o IgG level lower than 250 mg/dL
 - o Ataxia telangiectasia
 - o DiGeorge syndrome
 - o Other combined immunodeficiencies with significant hypogammaglobulinemia
 - o Unspecified hypogammaglobulinemia
 - o IgG subclass deficiency
 - o Selective antibody deficiency (SAD)
 - o Other primary immune deficiency confirmed by genetic or molecular testing
- For CVID, unspecified hypogammaglobulinemia, or other combined immunodeficiencies with significant hypogammaglobulinemia indication, must meet both of the following criteria:
 - o The pretreatment total IgG level is below the normal range (age-related and according to the normal reference range for the reporting laboratory); AND
 - o Has an impaired antibody response (i.e., failure to produce antibodies to specific antigen) OR has recurrent infections.
- For IgG subclass deficiency, selective antibody deficiency (SAD), or another confirmed primary immunodeficiency must have an impaired antibody response (i.e., failure to produce antibodies to specific antigen) and recurrent infections;
- The requested product is prescribed by or in consultation with one of the following physician specialists: allergist, immunologist, otolaryngologist (ear, nose, and throat

[ENT] physician), pulmonologist, or an infectious disease physician who treats patients with PI.

NOTE: An exception can be made for the impaired antibody response if, according to the prescriber, the delay caused by pre-vaccination and post-vaccination antibody measurement would be deleterious to the patient's health.

The individual must meet the following criterion for re-authorization:

- Has been diagnosed with a primary immunodeficiency and is continuing to receive benefit from the product (e.g., increased IgG levels, preventing or controlling infections).

Approval duration (initial and renewal): 12 months

Secondary Humoral Immunodeficiency:

Must have one of the following diseases/conditions:

- B-cell chronic lymphocytic leukemia
- Hematologic neoplasm-associated hypogammaglobulinemia
- Hypogammaglobulinemia after B-cell targeted therapies
- Post hematopoietic stem cell transplantation
- Human immunodeficiency virus (HIV) infection in pediatrics

B-Cell Chronic Lymphocytic Leukemia for Prevention of Infections

The individual must meet both of the following criteria for an initial authorization:

- Has an immunoglobulin G (IgG) level less than 600 mg/dL OR has a history of recurrent infections;
- The requested product is prescribed by or in consultation with an oncologist, hematologist, or infectious disease physician.

The individual must meet the following criterion for re-authorization:

- Is experiencing a positive response to therapy (e.g., maintaining an increased IgG trough level or a decrease in the number of infections).

Approval duration (initial): 4 months

Approval duration (renewal): 12 months

Hematologic Neoplasm-Associated Hypogammaglobulinemia or Hypogammaglobulinemia after B-cell Targeted Therapies

NOTE: Examples of B-cell targeted therapy are chimeric antigen receptor (CAR) T cell therapy (e.g., Kymriah [tisagenlecleucel injection], Abecma [idecabtagene vicleucel injection], Breyanzi [lisocabtagene maraleucel injection], Tecartus [brexucabtagene autoleucel injection], Yescarta [axicabtagene ciloleucel injection]), a rituximab product, and Besponsa (inotuzumab ozogamicin injection).

The individual must meet all of the following criteria for an initial authorization:

- Has an immunoglobulin G (IgG) level less than 600 mg/dL;
- Has recurrent or severe infections or has high risk of infection;
- The requested product is prescribed by or in consultation with an oncologist, hematologist, infectious disease physician, or immunologist.

The individual must meet the following criterion for re-authorization:

- Is experiencing a positive response to therapy (e.g., maintaining an increased IgG trough level or a decrease in the number of infections).

Approval duration (initial and renewal): 6 months

Post Hematopoietic Cell Transplantation (HCT) to Prevent Infection

The individual must meet all of the following criteria for an initial authorization:

- Has had a HCT within the previous year;
- Has an immunoglobulin G (IgG) level less than 600 mg/dL OR has multiple myeloma or malignant macroglobulinemia;
- Has a significant risk of having frequent and/or severe infections;
- The requested product is prescribed by or in consultation with a hematologist, oncologist, or infectious disease physician.

The individual must meet the following criterion for re-authorization:

- Is experiencing a positive response to therapy (e.g., maintaining an increased IgG trough level, controlling the number of infections, or a decrease in the number of infections).

Approval duration (initial): 3 months

Approval duration (renewal): 6 months

Human Immunodeficiency Virus (HIV)

The individual must meet the following criteria for an initial authorization:

- Is less than 18 years of age;
- Is receiving combination antiretroviral therapy;
- Meets one of the following:
 - o Has hypogammaglobulinemia (i.e., IgG less than 400 mg/dL); OR
 - o Functional antibody deficiency is demonstrated by poor specific antibody titers (i.e., does not develop specific antibody response against protein and polysaccharide antigens); OR
 - o Functional antibody deficiency is demonstrated by having recurrent (2 or more per year) serious infections (e.g., bacteremia, meningitis, pneumonia) despite administration of combination antiretroviral therapy and appropriate antimicrobial prophylaxis;
- The requested product is prescribed by or in consultation with an infectious disease specialist or an immunologist.

The individual must meet the following criterion for re-authorization:

- The frequency and/or severity of infections have decreased.

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

The individual must meet both of the following criteria for an initial authorization:

- The requested product is prescribed by or in consultation with a neurologist;
- Electrodiagnostic studies support the diagnosis of CIDP.

The individual must meet the following criterion for re-authorization:

- Must have a clinically significant improvement in neurologic symptoms (e.g., improvement in disability, nerve conduction study results improved or stabilized, physical examination show improvement in neurological symptoms, strength [e.g., grip strength], and sensation).

Approval duration (initial): 3 months

Approval duration (renewal): 12 months

Immune Thrombocytopenia (ITP)

The individual must meet the following criteria for an initial authorization:

- Must meet one of the following criteria:
 - o Is pregnant; OR
 - o Is less than 18 years of age; OR
 - o The request product is being used to increase platelet count before surgical or dental procedures; OR
 - o Is 18 years of age or older and has tried a systemic corticosteroid (e.g., prednisone) unless contraindicated OR has an urgent need to increase the platelet count quickly.
- The requested product is prescribed by or in consultation with a hematologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., increased platelet counts, absence of significant bleeding, or preventing hemorrhage/ensuring adequate platelet count in order for delivery in pregnant patients) OR has previously responded to therapy.

Approval duration (pregnancy): 6 months

Approval duration (prior to surgical or dental procedures): 1 month

Approval duration (initial): 3 months

Approval duration (renewal): 12 months

Kawasaki Disease

The individual must meet the following criterion for authorization:

- The requested product is prescribed by or in consultation with a pediatric cardiologist or a pediatric infectious disease physician.

Approval duration: 3 months

Multifocal Motor Neuropathy (MMN)

The individual must meet both of the following criteria for an initial authorization:

- The diagnosis of MMN is supported by weakness without sensory abnormalities, upper motor neuron signs, or marked bulbar involvement and meets one of the following:

- o The diagnosis is supported by nerve conduction studies that demonstrate motor conduction block or probable motor conduction block; OR
 - o Has MMN without conduction block; OR
 - o The diagnosis is supported by a motor nerve biopsy or by a magnetic resonance imaging (MRI) neurography;
- The requested product is prescribed by or in consultation with a neurologist.

The individual must meet the following criterion for re-authorization:

- Has improvement in neurologic symptoms (e.g., improvement in disability, grip strength improvement, physical examination shows improvement in neurological symptoms and strength).

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Antibody-Mediated Rejection (ABMR) in Transplantation

The individual must meet the following criterion for authorization:

- The requested product is prescribed by or in consultation with a physician affiliated with a transplant center.

Approval duration: 12 months

Autoimmune Mucocutaneous Blistering Diseases (pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, and epidermolysis bullosa acquisita)

The individual must meet the following criteria for an initial authorization:

- Must meet one of the following:
 - o Has tried both a systemic corticosteroid and an immunosuppressive agent (e.g., azathioprine, cyclophosphamide, methotrexate, cyclosporine, mycophenolate, tacrolimus) unless contraindicated to both agents; OR
 - o Has rapid, debilitating, progressive disease that cannot be controlled with a systemic corticosteroid and an immunosuppressive agent; OR
 - o Has a serious disease that there is inadequate time for therapy with a systemic corticosteroid and an immunosuppressive agent to have a rapid enough effect;
- The requested product is prescribed by or in consultation with a dermatologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., healing of previous lesions or fewer new lesions).

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Cytomegalovirus (CMV) Pneumonitis or Pneumonia

The individual must meet both of the following criteria for authorization:

- Has cancer or transplant-related infection;
- The requested product is prescribed by or in consultation with an oncologist, hematologist, or an infectious disease physician.

Approval duration: 2 months

Dermatomyositis or Polymyositis

The individual must meet all of the following criteria for an initial authorization:

- Prior to starting any therapy for this condition, must meet one of the following:
 - Has or had an elevated creatine kinase (CK) level; OR
 - Other measures support the diagnosis, including but not limited to, skin manifestations, autoantibody testing, muscle biopsy results, electromyographic (EMG) findings;
- Has tried a systemic corticosteroid unless contraindicated;
- Has tried an immunosuppressive agent (e.g., azathioprine, methotrexate, cyclosporine, cyclophosphamide, mycophenolate) unless contraindicated;
- The requested product is prescribed by or in consultation with a neurologist or a rheumatologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., improved muscle strength, neuromuscular symptoms, or functional ability).

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Desensitization Therapy Prior to and Immediately after Solid Organ Transplantation

The individual must meet the following criterion for authorization:

- The requested product is prescribed by or in consultation with a physician affiliated with a transplant center.

Approval duration: 12 months

Guillain Barre Syndrome (GBS)

The individual must meet both of the following criteria for an initial authorization:

- Meets one of the following:
 - The requested product will be initiated within 2 weeks and no longer than 4 weeks of onset of neuropathic symptoms (e.g., weakness, inability to stand or walk without assistance, respiratory or bulbar weakness); OR
 - Has had a relapse but had an initial response to IVIG;
- The requested product is prescribed by or in consultation with a neurologist or a specialist with experience in diagnosing and treating patients with GBS.

Approval duration (initial and renewal): 1 month

Human Immunodeficiency Virus (HIV)- or Hepatitis C- Associated Thrombocytopenia

The individual must meet both of the following criteria for authorization:

- Is receiving antiviral therapy;
- The requested product is prescribed by or in consultation with an infectious disease specialist, a physician who specializes in the treatment of HIV infection, a gastroenterologist, hepatologist, or a liver transplant physician.

Approval duration: 1 month

Lambert-Eaton Myasthenic Syndrome (LEMS)

The individual must meet all of the following criteria for an initial authorization:

- Is having refractory weakness after symptomatic treatment of LEMS with an amifampridine product (e.g., Firdapse, Ruzurgi), guanidine, or pyridostigmine.
- Meets one of the following:
 - Has paraneoplastic LEMS; OR
 - Has non-paraneoplastic LEMS and has tried a systemic corticosteroid or another immunosuppressive agent unless contraindicated to corticosteroid and/or immunosuppressive agents
- The requested product is prescribed by or in consultation with a neurologist.

The individual must meet the following criterion for re-authorization:

- Has shown a response to therapy (e.g., improved muscle strength, other clinical response) or continued effectiveness.

Approval duration (initial): 1 month

Approval duration (renewal): 12 months

Multiple Sclerosis (MS)

For acute severe exacerbation or relapses:

The individual must meet the following criteria for authorization:

- Meets one of the following:
 - Has not responded to or had a significant adverse reaction with systemic corticosteroids or plasma exchange; OR
 - Has a contraindication to systemic corticosteroids;
- Meets one of the following:
 - Is already on maintenance therapy for MS or will be starting maintenance therapy for MS; OR
 - Is pregnant or post-partum and maintenance therapy is not clinically appropriate;
- The requested product is prescribed by or in consultation with a neurologist or physician who specializes in the treatment of MS.

Approval duration: 1 month

Multiple Myeloma

The individual must meet the following criteria for an initial authorization:

- Meets one of the following:
 - Has or is at risk of severe, recurrent infections; OR
 - Will be starting, has taken, or is currently receiving chimeric antigen receptor (CAR)-T cell therapy or biospecific antibody therapy;
- The requested product is prescribed by or in consultation with a hematologist, oncologist, or infectious disease specialist

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Myasthenia Gravis

For an initial authorization request for short-term (acute) use:

- Has an exacerbation of myasthenia gravis; OR
- Requires stabilization of myasthenia gravis before surgery; OR
- Has started on an immunosuppressive drug (e.g., azathioprine, cyclosporine, cyclophosphamide, mycophenolate, methotrexate, tacrolimus) and is waiting for full effect; OR
- Is starting therapy with a corticosteroid and IVIG is being given to prevent or minimize exacerbations; AND
- The requested product is prescribed by or in consultation with a neurologist; OR
- Continuation of therapy in patients using immune globulin for short-term (acute) use; (to allow for one course of therapy).

Approval duration: 5 days

For maintenance use:

The individual must meet all of the following criteria for an initial authorization:

- Has refractory myasthenia gravis;
- Has tried pyridostigmine;
- Has tried at least one of the following immunosuppressive agents and had an inadequate response: azathioprine, cyclosporine, cyclophosphamide, mycophenolate, methotrexate, tacrolimus;
- The requested product is prescribed by or in consultation with a neurologist.

The individual must meet the following criterion for re-authorization:

- Is responding to IVIG therapy (e.g., improvement in weakness [bulbar, limb, or respiratory], improvement with ocular symptoms).

Approval duration (initial & renewal): 12 months

Stiff-Person Syndrome (Moersch-Woltman Syndrome)

The individual must meet both of the following criteria for an initial authorization:

- Has tried a benzodiazepine (e.g., diazepam) or baclofen OR has contraindication to both therapies;

- The requested product is prescribed by or in consultation with a neurologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., reduced stiffness or frequency of spasms, ability to walk unassisted).

Approval duration (initial): 3 months

Approval duration (renewal): 12 months

Pure Red Blood Cell Aplasia (PRCA)

The individual must meet all of the following criteria for initial authorization:

- Has tried a systemic corticosteroid (e.g., prednisone);
- Has tried either cyclophosphamide or cyclosporine;
- The requested product is prescribed by or in consultation with one of the following specialist: an infectious disease specialist, immunologist, hematologist, or transplant specialist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy with an increase in hemoglobin and reticulocytosis.

Approval duration (initial and renewal): 1 month

Parvovirus B19 Infection

The individual must meet both of the following criteria for initial authorization:

- Has an immunodeficiency condition (e.g., HIV infection, solid organ transplant, chemotherapy for hematologic malignancy);
- The requested product is prescribed by or in consultation with one of the following specialists: an infectious disease specialist, immunologist, hematologist, or transplant specialist.

Approval duration (initial): 2 months

Approval duration (renewal): 6 months

Post-Exposure Prophylaxis for Varicella OR Treatment or Post-Exposure Prophylaxis for Tetanus

The individual must meet one of the following criteria for authorization:

- For Varicella post-exposure, Varicella immune globulin is not available OR it cannot be administered; OR
- For tetanus treatment or post-exposure, tetanus immune globulin is not available.

Approval duration: single dose

Passive Immunization for Measles (post-Exposure Prophylaxis)

The individual must meet the following criteria for authorization:

- Has been exposed to measles;

- Meets one of the following:
 - o Is immunocompromised; OR
 - o Is pregnant and cannot readily show he/she has evidence of immunity against measles (i.e., does not have a history of the disease or age-appropriate vaccination).

Approval duration: single dose

Thrombocytopenia, Feto-neonatal Alloimmune

The individual must meet both of the following criteria for authorization:

- Is pregnant or newborn;
- The requested product is prescribed by or in consultation with a hematologist or an obstetrician.

Approval duration: 6 months

Myelin Oligodendrocyte Glycoprotein Antibody-Associated Disease (MOGAD)

The individual must meet all of the following criteria for an initial authorization:

- Has a clinical demyelinating event (e.g., optic neuritis, acute disseminated encephalomyelitis, transverse myelitis);
- The diagnosis was confirmed by a positive blood serum test with positive for myelin oligodendrocyte glycoprotein (MOG)-Immune globulin G (IgG);
- Meets one of the following:
 - o Is using the requested product for the treatment of acute attacks and has tried a systemic corticosteroid unless contraindicated; OR
 - o Is using the requested product for attack prevention and has tried an immunosuppressant unless contraindicated;
- The requested product is prescribed by or in consultation with a neurologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., reduction in relapse rate, slowing of disability, slowing in the progression of symptoms).

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor Therapy

Examples of checkpoint inhibitors are Keytruda (pembrolizumab injection), Opdivo (nivolumab injection), Yervoy (ipilimumab injection), Tecentriq (atezolizumab injection), Bavencio (avelumab injection), Imfinze (durvalumab injection), Libtayo (cemiplimab injection), Jemperli (dostarlimab injection).

The individual must meet one of the following criteria for an initial authorization:

- Has tried a systemic corticosteroid (e.g., prednisone, methylprednisolone) and has not adequately responded to therapy; OR
- The requested product is being started with a systemic corticosteroid; OR
- A corticosteroid is contraindicated.

The individual must meet the following criterion for re-authorization:

- Is having a positive response to therapy and extended therapy is required.

Approval duration (initial): 1 month

Approval duration (renewal): 6 months

Aquaporin-4 Immunoglobulin Antibodies (AQP4-IgG)-Positive Neuromyelitis Optica Spectrum Disorder (NMOSD)

The individual must meet all of the following criteria for an initial authorization:

- Has the presence of at least one core clinical feature of NMOSD (e.g., optic neuritis, acute myelitis, acute brainstem syndrome);
- The diagnosis was confirmed by a positive blood serum test for AQP4-IgG; *Note: Detection in cerebral spinal fluid would also satisfy this requirement*
- Is using the requested product for attack prevention and meets one of the following:
 - Is less than 18 years of age; OR
 - Has tried or has a contraindication to one other therapy for this condition (e.g., azathioprine, mycophenolate mofetil, rituximab, eculizumab, Ultomiris, Uplizna).
- The requested product is prescribed by or in consultation with a neurologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., reduction in relapse rate, reduction in symptoms, slowing in the progression of symptoms).

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Immune-Mediated Necrotizing Myopathy

The individual must meet all of the following criteria for an initial authorization:

- Has muscle weakness;
- Has or had an elevated creatine kinase (CK) level above 1,000 IU/L;
- Meets one of the following:
 - Has myositis-associated autoantibodies (e.g., anti-SRP autoantibodies, anti-HMGCR autoantibodies); OR
 - Has an electromyography, muscle magnetic resonance imaging, or muscle biopsy that supports the given diagnosis;
- Meets one of the following:
 - Has tried a systemic corticosteroid; OR
 - Has a contraindication to corticosteroids; OR
 - Has tried rituximab, methotrexate, mycophenolate, or tacrolimus; OR
 - Has anti-HMGCR autoantibodies;
- The requested product is prescribed by or in consultation with a neurologist or rheumatologist.

The individual must meet the following criterion for re-authorization:

- Is responding to therapy (e.g., improved muscle strength, improved functional ability, CK decrease).

Approval duration (initial): 6 months

Approval duration (renewal): 12 months

Dosing Recommendations

Flebogamma/Octagam

Primary immunodeficiency (PI): The recommended dose is 300 to 600 mg/kg administered intravenously every 3 to 4 weeks.

Immune thrombocytopenia (ITP): The recommended dose is 1 g/kg administered intravenously daily for 2 consecutive days.

Gammagard Liquid

PI: The recommended dose is 300 to 600 mg/kg administered intravenously every 3 to 4 weeks.

Multifocal motor neuropathy (MMN): The recommended dose is 0.5 to 2.4 g/kg administered intravenously per month based on clinical response.

Gammagard S/D

PI: The recommended dose is 300 to 600 mg/kg administered intravenously every 3 to 4 weeks.

B-cell chronic lymphocytic leukemia: The recommended dose is 400 mg/kg administered intravenously every 3 to 4 weeks.

Kawasaki syndrome: The recommended dose is a single 1 g/kg or a dose of 400 mg/kg for 4 consecutive days administered intravenously beginning within seven days of the onset of fever.

ITP: The recommended dose is 1 g/kg administered intravenously. The need for additional doses can be determined by clinical response and platelet count. Up to three separate doses may be given on alternate days if required.

Gammaked/Gamunex-C

PI: The recommended dose is 300 to 600 mg/kg administered intravenously every 3 to 4 weeks.

ITP: The recommended dose is 2 g/kg, divided in two doses of 1 g/kg given intravenously on two consecutive days or into five doses of 0.4 g/kg given on five consecutive days.

Chronic inflammatory demyelinating polyneuropathy (CIDP): The recommended dose is loading dose 2 g/kg administered intravenously in divided doses over 2 to 5 consecutive

days following with maintenance dose of 1 g/kg administered intravenously in divided doses over 1 to 4 consecutive days, every 3 weeks.

Gammaplex

PI: The recommended dose is 300 to 800 mg/kg administered intravenously every 3 to 4 weeks.

ITP: The recommended dose is 1 g/kg administered intravenously for 2 consecutive days.

Privigen

PI: The recommended dose is 200 to 800 mg/kg administered intravenously every 3 to 4 weeks.

ITP: The recommended dose is 1 g/kg administered intravenously for 2 consecutive days.

CIPD: The recommended dose is loading dose 2 g/kg administered intravenously in divided doses over 2 to 5 consecutive days following with maintenance dose of 1 g/kg administered in 1 to 2 infusions on consecutive days, every 3 weeks.

Panzyga

PI: The recommended dose is 300 to 600 mg/kg administered intravenously every 3 to 4 weeks.

ITP: The recommended dose is 1 g/kg administered intravenously on 2 consecutive days.

CIDP: The recommended loading dose is 1g/kg administered intravenously on 2 consecutive days. Maintenance dose is 1-2 g/kg every 3 weeks divided in 2 doses given over 2 consecutive days.

Bivigam

PI: The recommended dose is 300 to 800 mg/kg administered intravenously every 3 to 4 weeks.

Asceniv

PI: The recommended dose is 300 to 800 mg/kg administered intravenously every 3 to 4 weeks.

Alyglo

PI: The recommended dose is 300 to 800 mg/kg administered intravenously every 3 to 4 weeks.

Yimmugo

PI: The recommended dose is 300 to 800 mg/kg administered intravenously every 3 to 4 weeks.

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