Payment Policy | Intravenous Immune Globulin Therapy

EFFECTIVE DATE: 11/04/2008
POLICY LAST UPDATED: 12/04/2012

OVERVIEW

This payment policy documents the coverage for Intravenous Immune Globulin Therapy. Intravenous immune globulin (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.

PRIOR AUTHORIZATION

Prior authorization is not required.

POLICY STATEMENT

BlueCHiP for Medicare and Commercial products

Intravenous Immune Globulin Therapy is covered.

MEDICAL CRITERIA

Not Applicable

BACKGROUND

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.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement for applicable infusion benefits/coverage.

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

Specialty Pharmacy:

For contracts with specialty drug coverage, please refer to the member agreement for benefits and preauthorization guidelines.

CODING

Blue CHiP for Medicare and Commercial Products

CPT:
90283

HCPCS:
J1557 J1566

RELATED POLICIES

None

PUBLISHED

Provider Update	Feb 2013
Provider Update	Dec 2008
Policy Update	Jan 2008
Policy Update	Jan 2007
Policy Update	Jan 2006
Policy Update	Jan 2005
Policy Update	Sep 2000

REFERENCES

None

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