

Criteria-Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

immune globulin subcutaneous (human) 10%, with recombinant human hyaluronidase (Hyqvia)

Notes:

* Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment, and do not require medication discontinuation

Initiation (new start) criteria: Non-formulary **immune globulin subcutaneous (human) 10%, with recombinant human hyaluronidase (Hyqvia)** will be covered on the prescription drug benefit when the following criteria are met:

- Prescriber is an Allergist or Neurologist
- Patient has documented contraindication, intolerance*, or treatment failure to immune globulin subcutaneous (human) 20% (Hizentra)

Criteria for current Kaiser Permanente members already taking the medication who have not been reviewed previously: Non-formulary **immune globulin subcutaneous (human) 10%, with recombinant human hyaluronidase (Hyqvia)** will be covered on the prescription drug benefit when the following criteria are met:

- Prescriber is an Allergist or Neurologist
- Patient has documented contraindication, intolerance*, or treatment failure to immune globulin subcutaneous (human) 20% (Hizentra)

Criteria for new members entering Kaiser Permanente already taking the medication who have not been reviewed previously: Non-formulary **immune globulin subcutaneous (human) 10%, with recombinant human hyaluronidase (Hyqvia)** will be covered on the prescription drug benefit when the following criteria are met:

- Prescriber is an Allergist or Neurologist
- Patient has documented contraindication, intolerance*, or treatment failure to immune globulin subcutaneous (human) 20% (Hizentra)