Criteria-Based Consultation Prescribing Program
CRITERIA FOR DRUG COVERAGE

Immune globulin subcutaneous, human – klhw, 20% (Xembify)

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 – klhw, 20% (Xembify)** 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 – klhw, 20% (Xembify)** 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 – klhw, 20% (Xembify)** 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)