STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

HYQVIA® (Human Immune Globulin 10% infusion)
Prior Authorization Request Form

HyQvia is a subcutaneous immune globulin (IG) infusion 10% (human) with recombinant human hyaluronidase indicated for the treatment of Primary Immundeficiency (PI) in adults. HyQvia contains recombinant human hyaluronidase which increases dispersion and absorption of the immune globulin allowing a full therapeutic dose in one subcutaneous infusion site.

Prior authorization requests for HyQvia will be approved if the following criteria are met:

1.) Patient must be eighteen (18) years of age or older; **AND**
2.) Diagnosis of primary humoral immunodeficiency, which includes, but is not limited to congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia Wiskott-Aldrich syndrome, and severe combined immunodeficiencies; **AND**
3.) The initial dose of HyQvia should be administered in a healthcare setting capable of monitoring for and treating hypersensitivity reactions. All subsequent doses may be administered at home or in a home care setting.

Any indication not otherwise specified shall be reviewed for prior-authorization on a case-by-case basis with the assumption that all supporting evidence has been submitted along with the request for coverage.

References

Lexi-Comp drug monograph for HyQvia (Nov. 10th, 2014)
www.HyQvia.com
HyQvia package insert (rev 9/2014)

Version 4 Review and Approved
DUR Board 11/19/2014