Reference number(s)
3243-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Subcutaneous Immune Globulin (SCIG) Products

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), and Advanced Control Specialty – Choice Formulary (ACSCF).

Plan Design Summary

This program applies to the subcutaneous immune globulin (SCIG) products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Targeted Subcutaneous Immune Globulin Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• Cutaquig

	Product(s)
Target	• Cuvitru • HyQvia

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for a targeted product is provided when the member has a documented inadequate response or intolerable adverse event with the preferred product.

References

1. Cuvitru [package insert]. Lexington, MA: Baxalta US Inc.; March 2023.
2. HyQvia [package insert]. Lexington, MA: Baxalta US Inc.; April 2023.
3. Cutaquig [package insert]. Paramus, NJ: Octapharma USA, Inc.; November 2021.