Louisiana Medicaid
Immune Globulin Intravenous, Human-stwk (Alyglo™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for immune globulin intravenous, human-stwk (Alyglo™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria

- The recipient is within the age parameters defined by the drug-specific prescribing information; **AND**
- **ONE** of the following is required:
    - The recipient has a diagnosis of primary humoral immunodeficiency*; **OR**
    - The requested medication is being used for a medically accepted indication as defined using the following sources and source(s) are **stated on the request**:
        - Micromedex; **OR**
        - American Hospital Formulary Service (AHFS); **OR**
        - Disease state specific standard of care guidelines; **AND**
- Previous use of a preferred product - **ONE** of the following is required: (See 'Immune Globulins' therapeutic class on the PDL)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
    - The recipient is established on the medication with positive clinical outcomes; **AND**
- The diagnosis for which the medication is requested has been confirmed by a specialist [Name of specialist must be **stated on the request**]; **AND**
- The requested dose is consistent with FDA approved package labeling, nationally recognized compendia, or peer-reviewed literature; **AND**
- The recipient has tried and failed, or has a documented medical reason for not using, all other standard of care therapies as defined per recognized guidelines [Dates and medications must be **stated on the request**].

**Primary humoral immunodeficiency includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiency (SCID).*

Duration of approval: 6 months

Reference

Alyglo (immune globulin intravenous, human-stwk) [package insert]. Teaneck, NJ: GC Biopharma USA, Inc; December 2023. https://hcp.alyglo.com/alyglo_pi.pdf

Revision / Date	Implementation Date
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