Change form for published clinical commissioning policies, commissioning policies and commissioning statements developed by Clinical Reference Group (CRGs)

Product name: Clinical commissioning policy for the use of therapeutic immunoglobulin (Ig) England (2024)

Publication number:

Summary of the rationale and the change: A number of amendments to the published policy have been requested by the clinical community and signed off by the Immunoglobulin Oversight Group, chaired by the National Clinical Director for the Blood and Infection Programme of Care.

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
New indications section	Removed	Executive Summary Plain language summary	No longer considered "new"	Senior Pharmacy Lead	January 2025
Links and updates to other policies	Added: • Commissioning Criteria Policy for the use of	Links and updates to other policies	To reflect current update	Senior Pharmacy Lead	February 2025

	therapeutic immunoglobulin (Ig) England, 2024				
Haematopoeitic stem cell transplantation (HSCT) in primary immunodeficiencies (PID) / inborn errors of immunity (IEI) – long term use long term use	Haematopoeitic stem cell transplantation (HSCT) in primary immunodeficiencies (PID) / inborn errors of immunity (IEI) – long term use	Appendix A: Use of Immunoglobulin in Immunology	Word repetition	Lead Commissioner, Immunology & Allergy	January 2025
• In patients developing **hypogammaglobinaemia associated with B -cell aplasia as a consequence of Chimeric Antigen Receptor – T cell therapy (CAR -T cells)** targeted against B cell antigens, the prophylactic use of Ig in the absence of a burden of severe infections and vaccine challenge may be appropriate	• In patients developing **hypogammaglobinaemia associated with B-cell aplasia as a consequence of Chimeric Antigen Receptor – T cell therapy (CAR-T cells)** targeted against B cell or plasma cell antigens, the prophylactic use of Ig in the absence of a burden of severe infections and vaccine challenge may be appropriate	Appendix A: Use of Immunoglobulin in Immunology Secondary antibody deficiency – long term use	Updated clinical evidence	Ig Oversight Group	September 2024
• Use of Ig post-CAR-T cell therapy in B-cell lymphoma The need for Ig replacement in patients receiving CAR-T cell therapy for B-cell lymphoma is variable ranging between 31% to 64% in published studies	• Use of Ig post-CAR-T cell therapy in B-cell lymphoma The need for Ig replacement in patients receiving CAR-T cell therapy for B-cell lymphoma is variable ranging between 31% to 64% in published studies	Appendix A: Use of Immunoglobulin in Immunology Secondary antibody deficiency – long term use	Updated clinical evidence	Ig Oversight Group	December 2024

highlighting faster B-cell recovery in this group in contrast to patients with B-cell acute lymphoblastic leukaemia	highlighting faster B-cell recovery in this group in contrast to patients with B-cell acute lymphoblastic leukaemia • Use of Ig at inception of bi-specific antibody treatment in patients with myeloma and B-cell lymphoma Many patients in these disease groups will have a low serum IgG at baseline due to previous chemo-immunotherapy, including CD20 and CD38 depleting agents. The prophylactic use of Ig would be appropriate in patients with a serum IgG of < 4g/l at the time of commencement of a bi-specific antibody.				
• Parvovirus B19 infection confirmed by PCR, AND • Evidence of high viral load, usually above 109 IU/ml	• Parvovirus B19 infection confirmed by PCR, AND • Evidence of high viral load, usually above 10^9 IU/ml	Appendix A: Use of Immunoglobulin in Haematology Acquired red cell aplasia	Typo	National Clinical Director, Blood and Infection	September 2024

		associated with chronic parvovirus B19 infection – short term use			
Covid vaccine-induced thrombosis and thrombocytopenia (VITT)	Covid vaccine-induced immune thrombotic thrombocytopenia (VITT) or a syndrome of anti-PF4 (platelet factor 4) associated immune-mediated thrombosis and thrombocytopenia	Appendix A: Use of Immunoglobulin in Haematology Covid vaccine-induced thrombosis and thrombocytopenia (VITT)	Updated terminology	Ig Oversight Group	December 2024
Covid vaccine-induced thrombosis and thrombocytopenia (VITT) See NICE guideline NG200	Reference to NICE guideline and footnote removed	Appendix A: Use of Immunoglobulin in Haematology Covid vaccine-induced thrombosis and thrombocytopenia (VITT)	NICE guideline has been withdrawn	Senior Pharmacy Lead	February 2025
Eculizumab is commissioned as a 2nd line treatment where 1st line treatment has failed; Rituximab is recommended as a 3rd line treatment	Moved from Exclusion criteria to Position of immunoglobulin	Appendix A: Use of Immunoglobulin in Haematology Prevention of delayed	Additional clarity	Lead Commissioner, Immunology & Allergy	February 2025

		haemolytic transfusion reaction			
Ig may be required to obtain rapid control, but may be substituted for by prednisolone, mycophenolate mofetil, plasma exchange or other immunosuppressants which are preferable in the longer term	Ig may be required to obtain rapid control, but may be substituted by prednisolone, mycophenolate mofetil, plasma exchange or other immunosuppressants which are preferable in the longer term	**Appendix A: Use of Immunoglobulin in Neurology** Acute idiopathic/ autoimmune dysautonomia/ ganglionopathy	Typo	National Clinical Director, Blood and Infection	February 2025
• Reduction in in numbers of syncopal and pre-syncopal episodes	• Reduction in numbers of syncopal and pre-syncopal episodes	**Appendix A: Use of Immunoglobulin in Neurology** Acute idiopathic/ autoimmune dysautonomia/ ganglionopathy	Word repetition	Lead Commissioner, Immunology & Allergy	January 2025
None	For those disease indications in children and young adults where IVIg and plasma exchange (PLEX) are equally efficacious, IVIg may be preferentially considered if poor peripheral venous access or challenges in service delivery preclude the use of PLEX	**Appendix A: Use of Immunoglobulin in Neurology** Guillain-Barre syndrome (GBS) and	Guidance for use of Ig in children where plasma exchange may be problematic for logistical reasons	Ig Oversight Group	February 2024

		General notes: Dosing optimisation in neurology for maintenance			
• CK for baseline and asses how a patient has improved after each infusion or at least after 3 infusions.	• CK for baseline and assess how a patient has improved after each infusion or at least after 3 infusions.	**Appendix A: Use of Immunoglobulin in Neurology** Inflammatory Myopathies - Dermatomyositis (DM), Juvenile dermatomyositis (JDM), Polymyositis (PM), Other inflammatory myopathies	Typo	Lead Commissioner, Immunology & Allergy	January 2025
• If no significant measurable and functionally meaningful improved in abilities had been achieved after 3 doses Ig should be stopped.	• If no significant measurable and functionally meaningful improvement in abilities had been achieved after 3 doses Ig should be stopped.	**Appendix A: Use of Immunoglobulin in Neurology** Stiff person syndrome (SPS) or variant	Typo	Lead Commissioner, Immunology & Allergy	January 2025

Public Health England. Guidelines on Post-Exposure Prophylaxis for measles. Available from: *Guidelines on Post-Exposure Prophylaxis for measles June 2019 (publishing.service.gov.uk)*	UK Health Security Agency. National measles guidelines. Available from: *National measles guidelines July 2024*	**Appendix A: Use of Immunoglobulin in Infectious Diseases** Measles (immunosuppressed individuals)	Updated UKHSA Guidance	Senior Pharmacy Lead	October 2024
For immunosuppressed contacts Ig is mainstay management	For immunosuppressed contacts Ig is the mainstay of management	**Appendix A: Use of Immunoglobulin in Infectious Diseases** **Measles (immunosuppressed individuals)**	Grammatical error	National Clinical Director, Blood and Infection	February 2025
0.15 g/kg of Ig recommended ideally within 72 hours of exposure although can be given up to 6 days. Where exposure recognised late or found to be antibody negative between 6 and 18 days after exposure, Ig may be considered following discussion with specialist clinician.	0.15 g/kg of IVIg recommended ideally within 72 hours of exposure although can be given up to 6 days. Where exposure recognised late or found to be antibody negative between 6 and 18 days after exposure, IVIg may be considered following discussion with specialist clinician.	**Appendix A: Use of Immunoglobulin in Infectious Diseases** **Measles (immunosuppressed individuals)**	Additional clarity	UKHSA	February 2025

Pregnant women who have identified as susceptible based on vaccine history and /or antibody testing who have had a significant exposure to measles. Infants under 9 months of age with a significant exposure to measles. Advice is available at: https://www.gov.uk/government/publications/measles-post-exposure-prophylaxis	Pregnant women who have identified as susceptible based on vaccine history and /or antibody testing who have had a significant exposure to measles. Infants under 9 months of age with a significant exposure to measles. Advice is available at: National measles guidelines - GOV.UK	**Appendix A: Use of Immunoglobulin in Infectious Diseases** **Measles (pregnant women and infants)**	Updated UKHSA Guidance	Senior Pharmacy Lead	October 2024
Recommended dose • For pregnant contacts, approximately 3000mg of human normal Ig (HNIG) • Infants 0.6 ml/kg up to a maximum of 1000mg of HNIG HNIG to be given within 6 days of exposure in pregnant women and infants.	Recommended dose • For pregnant contacts, approximately 3000mg of human normal Ig (HNIG) • Infants 0.6 ml/kg up to a maximum of 1000mg of HNIG HNIG to be given within 6 days of exposure in pregnant women and infants. The National Measles Guidance (referenced in column 2), Section 2.3.2 recommends these doses are	**Appendix A: Use of Immunoglobulin in Infectious Diseases** **Measles (pregnant women and infants)**	Updated UKHSA Guidance	UKHSA	February 2025

	administered IM, using the SC formulations, as long as use via this route is acknowledged to be off-label.				
Person with clinical symptoms suggestive of localised or generalised tetanus ("in the absence of a more likely diagnosis, an acute illness with muscle spasms or hypertonia AND diagnosis of tetanus by a healthcare provider")	Person with clinical symptoms suggestive of localised or generalised tetanus ("in the absence of a more likely diagnosis, an acute illness with muscle spasms or hypertonia AND diagnosis of tetanus by a healthcare provider") Guidance on the management of suspected tetanus cases and the assessment and management of tetanus-prone wounds - GOV.UK	**Appendix A: Use of Immunoglobulin in Infectious Diseases** **Suspected tetanus case**	Updated UKHSA Guidance	UKHSA	February 2025
Ig – subcutaneous (SCIg) / intramuscular (IMIg): If TIg (for im use) cannot be sourced, Ig for subcutaneous or intra-muscular use may be given as an alternative. Based on testing for the presence of anti-tetanus antibodies of alternative Ig products, the volume required to achieve the recommended dose of 250 IU are included.	**Ig – subcutaneous (SCIg) / intramuscular (IMIg):** If TIg (for im use) cannot be sourced, Ig for subcutaneous or intra-muscular use may be given as an alternative. Based on testing for the presence of anti-tetanus antibodies of alternative Ig products, the volume required to achieve the recommended dose of 250 IU are included: Guidance on the	**Appendix A: Use of Immunoglobulin in Infectious Diseases** **Tetanus prone injury (prophylaxis)**	Updated UKHSA Guidance	UKHSA	February 2025

	management of suspected tetanus cases and the assessment and management of tetanus-prone wounds - GOV.UK.				
Varicella zoster	Details for varicella zoster updated in line with latest national guidance.	**Appendix A: Use of Immunoglobulin in Infectious Diseases** Varicella zoster	Updated UKHSA Guidance	UKHSA	February 2025
Ig is reserved for exceptional cases where anti-TNF agents are contra-indicated or ineffective or associated with intolerable adverse effects and other corticosteroid and immunosuppressive agents are ineffective. Adalimumab is regarded as the treatment of choice for the treatment of severe, refractory uveitis and is routinely commissioned by NHS England. (NICE TA460).	Ig is reserved for exceptional cases where conventional immunosuppressive agents are contra-indicated or ineffective or associated with intolerable adverse effects, especially in the context of autoimmune retinopathy. Adalimumab is regarded as the treatment of choice for other forms of severe, refractory uveitis and is routinely commissioned by NHS England. (NICE TA460).	**Appendix A: Use of Immunoglobulin in Other Indications** Autoimmune uveitis - short term use	To clarify that the only indication for Ig in autoimmune uveitis is a rare subtype called autoimmune retinopathy, which is antibody mediated and not treated with adalimumab.	Ig Oversight Group	September 2023

None	New indication added for scleromyxedema	**Appendix A: Use of Immunoglobulin in Other Indications**	Policy approved for routine commissioning	Dermatology Lead Commissioner	April 2024
An ongoing issue for diseases that require long-term Ig treatment is that once significant and functional responsiveness to intravenous Ig (IVIg) is demonstrated for a patient using standard immunomodulatory dosing, the 'maintenance' dosing required to maintain the therapeutic response is not well characterised. In this update, the dosing recommendations for some neurological indications include 'time to relapse' as the interval between doses. This approach is supported by evidence from The Oxford Programme for Immunomodulatory Immunoglobulin Therapy, which was set up to review multifocal motor neuropathy (MMN) and chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) treatment with	An ongoing issue for diseases that require long-term Ig treatment is that once significant and functional responsiveness to intravenous Ig (IVIg) is demonstrated for a patient using standard immunomodulatory dosing, the 'maintenance' dosing required to maintain the therapeutic response is not well characterised. In this update, the dosing recommendations for some neurological indications include 'time to relapse' as the interval between doses. This approach is supported by evidence from The Oxford Programme for Immunomodulatory Immunoglobulin Therapy, which was set up to review multifocal motor neuropathy (MMN) and chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) treatment with	**General notes: Dosing optimisation in neurology for maintenance**	To reflect clinical practice and provide greater clarity regarding dose titration	Ig Oversight Group	November 2024

immunoglobulin. In view of the uncertainty of both remission and disease progression in CIDP and MMN, The Oxford Programme reviewed the dose and infusion frequency of patients on a regular basis and showed that increasing the infusion interval proved successful in some patients and resulted in treatment discontinuation.	immunoglobulin. In view of the uncertainty of both remission and disease progression in CIDP and MMN, The Oxford Programme reviewed the dose and infusion frequency of patients on a regular basis and showed that increasing the infusion interval proved successful in some patients and resulted in treatment discontinuation. Very rarely, a small minority of patients with CIDP and MMN may require higher doses of Ig (> 2g/kg/every 6 weeks) as maintenance treatment. Such patients should be closely monitored either in or in close liaison with specialist centres with specific expertise in the management of autoimmune neuropathies. Regular reasonable disease-relevant attempts should be made to establish continued requirements or the minimum effective dose by supported cessation trials, down titration of dose or extending the interval between infusions.				