

May 28, 2010

Customer Advocate Team
Wonting Insurance Co
100 Main St
Anywhere, USA 00000

RE: Patient
Provider: Dr. Myo
Service: IVIg
Date of service: Prior authorization for IVIg (proposed start date 6/11/2010)

Dear Sir or Madam:

I am writing on behalf of Ms. Ms. Patientto initiate an appeal of Wonting's denial of coverage of Intravenous Immunoglobulin (IVIg) for treatment of polymyositis (PM). The appeal form, a release authorizing me to represent Ms. Ms. Patientin this appeal, and my HIPAA release is enclosed.

Wonting's initial denial was based on the fact that IVIg is an "off-label" use for PM. However, there is a large amount of medical literature supporting the use of IVIg as a second-line treatment for PM. Indeed, many other insurers cover IVIg for treating PM when other treatments fail, as they have in this case. Ms. Patient's medical records support Dr. Myo's clinical judgment that she is at risk of developing a more progressive form of the disease and, thus, that this treatment is called for **immediately**.

For these reasons, we ask that Wonting reverse its decision and permit Ms. Ms. Patient to undergo a trial of IVIg to see if her PM responds as well as Dr. Myo anticipates.

I. IVIg IS MEDICALLY NECESSARY – INDEED, ESSENTIAL – IN THIS CASE

Ms. Patient is a 30 year old female who went to Hopeful Hospital on September 19, 2007 to consult with a liver specialist, Dr. Hepatica. She had been having serious health problems for the previous 6 months. Symptoms started in late March with stiff hands and neck that continued to get worse. Only a month later, she already had trouble sitting down and no longer could climb stairs. A spinal tap ruled out meningitis (*See* June 2007 spinal tap results). Several tests for Lyme disease came back inconclusive, but liver enzymes consistently were about three times higher than normal. (*See* blood test results from March, April and June 2007). By the time she came to Hopeful Hospital, she was having trouble breathing and swallowing and could barely walk. (*See* Dr. Hepatica's September 19, 2007 initial exam summary.)

Dr. Hepatica admitted her to Hopeful Hospital immediately for more tests. A test for HIV came back negative, but creatine phosphokinase (CPK) levels were over 10,000 (normal is between 55 and 127). (See September 20, 2007 blood test results.) Dr. Hepatica diagnosed PM and confirmed his diagnosis with a muscle biopsy. (See September 22, 2007 muscle pathology report). Dr. Hepatica released Ms. Patient on September 23 with a prescription for 60 mg of Prednisone per day (See Sept. 23, 2007 Hopeful Hospital discharge summary).

On October 1, 2007, Ms. Patient went to see Dr. Myo, a Rheumatologist. Dr. Myo prescribed Methotrexate, an immunosuppressant, in addition to the Prednisone. (See Oct. 1, 2007 Myo exam summary). Still, CPK levels remained relatively stable for nearly two years. (See blood test results). However, during that time, Ms. Patient developed lung damage from the Methotrexate. (See August 8, 2009 exam summary from Dr. Doctor, a pulmonologist). Therefore, Dr. Myo changed Patient's prescription to Imuran, also an immunosuppressant but, hopefully, with fewer side effects. However, by May 20, 2010, the Imuran no longer was working; CPK levels were increasing rapidly. (See March, April and May blood test results). It is at this point that Dr. Myo requested IVIg for Patient. (See May 20, 2010 Myo note requesting authorization for IVIg).

It is urgent that Ms. Patient receive this treatment immediately. There is no treatment available to Ms. Patient that carries with it the same promise of safety and efficacy as IVIg. Corticosteroids showed no improvement. Methotrexate caused lung damage. Imuran no longer is working. Therefore, IVIg is the best option for this young woman whose health is deteriorating rapidly. The medical literature supports this use of IVIg as a safe and effective medication for treating PM.

II. IVIg IS AN ACCEPTED THERAPY FOR PM

Wanting Insurance has denied coverage of IVIg for PM on the ground that it is experimental or investigational. In some sense, every treatment for PM is experimental because it is rare and there are not large enough cohorts to conduct large, long-term, randomized, double-blind studies. However, this is not an argument for denying all treatment. Lack of treatment can lead to serious consequences. "If left untreated, inflammatory myopathy¹ can cause permanent disability." National Institute of Neurological Disorders and Stroke (NINDS). "Inflammatory Myopathies Fact Sheet." http://www.ninds.nih.gov/disorders/inflammatory_myopathies/detail_inflammatory_myopathies.htm. (Last accessed 5/20/10)

NINDS goes on to describe the specific progress and treatment of PM as follows:

Polymyositis affects skeletal muscles (involved with making movement) on both sides of the body. It is rarely seen in persons under age 18; most cases are in

¹ PM is one form of inflammatory myopathy.

patients between the ages of 31 and 60. In addition to symptoms listed above, progressive muscle weakness leads to difficulty swallowing, speaking, rising from a sitting position, climbing stairs, lifting objects, or reaching overhead. Patients with polymyositis may also experience arthritis, shortness of breath, and heart arrhythmias. . . .

Polymyositis and dermatomyositis² are first treated with high doses of prednisone or another corticosteroid drug. This is most often given as an oral medication but can be delivered intravenously. Immunosuppressant drugs, such as azathioprine [Imuran] and methotrexate, may reduce inflammation in patients who do not respond well to prednisone. **Periodic treatment using intravenous immunoglobulin can further recovery in patients with dermatomyositis or polymyositis.**

NINDS, supra (emphasis added). As you can see, Dr. Myo has followed the treatment guidelines recommended by NINDS to date – with IVIg being the next reasonable step. Thus, Ms. Ms. Patient should at least be given a trial of IVIg to see if it will stop her steady decline.

Several articles from the medical literature also indicate that a trial with IVg is indicated at this point. As Illa states, “PM is possibly the most infrequent of the inflammatory myopathies.” Because of that, “[t]here are no randomized [sic] trials in PM. However, **there are a number of publications that show efficacy in PM patients treated with IVIg.**” Illa, I., “IVIg in myasthenia gravis, Lambert Eaton myasthenic syndrome and inflammatory myopathies: current status,” *J Neurol* (2005) 252 [Suppl 1]: I/14–I/18 (emphasis added). Saito concludes that his study “indicates that IVIG therapy is effective for steroid-resistant PM/DM.” Saito, E. “Efficacy of high-dose intravenous immunoglobulin therapy in Japanese patients with steroid-resistant polymyositis and dermatomyositis,” *Mod Rheumatol*. 2008;18(1):34-44. Epub 2008 Jan 25. ,Cherin adds, “Corticosteroids remain the mainstay of treatment in PM and DM. In patients refractory or intolerant to corticosteroids, another therapy, often an immunosuppressive agent, or intravenous immunoglobulin (IVIg), is added.” Chérin P. **[Current therapy for polymyositis and dermatomyositis]**, *Rev Med Interne.*, 2008 Jun;29 Spec No 2:9-14.

Genevay, et al., even found that, “**Lower dose IV immunoglobulins** as a maintenance treatment were used with excellent results in a case of refractory polymyositis allowing considerable reduction in treatment costs.” Genevay, S., et al., “Intravenous gammaglobulins in refractory polymyositis: lower dose for maintenance treatment is effective.” *Ann Rheum Dis*. 2001 June; 60(6): 635–636 (emphasis added). Greenberg summarizes, “Intravenous immunoglobulin is useful for some patients with DM and PM. It can be used (1) as initial treatment in severely affected patients with a

² Dermatomyositis or DM is another form of inflammatory myopathy similar in some ways to polymyositis. Much of the medical literature discusses treatment for both PM and DM together.

goal of more rapid improvement, (2) occasionally as maintenance therapy in otherwise refractory patients, or (3) to reduce long-term corticosteroid use. Greenberg, S.A. "Inflammatory Myopathies: Evaluation and Management," *Semin Neurol* 2008;28:241–249.

Wada and his team's experimentation with mice further uncover the mechanism of IVIg's effect on PM. They found that IVIg suppresses the development of muscle lesions and conclude, "the observed effect of IVIG on EAM mice may provide the rational reason for its clinical use in PM and DM patients." Wada J., et al. "Intravenous immunoglobulin prevents experimental autoimmune myositis in SJL mice by reducing anti-myosin antibody and by blocking complement deposition," *Clin Exp Immunol*. 2001 May; 124(2): 282–289.

The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) and the European Federation of Neurological Societies (EFNS) both recommend IVIg as a second-line treatment for PM. Donofrio, P.D., et al., "Consensus statement: the use of intravenous immunoglobulin in the treatment of neuromuscular conditions report of the AANEM ad hoc committee." *Muscle Nerve*. 2009;40(5):890-900. Elovaara I., et al. "EFNS guidelines for the use of intravenous immunoglobulin in treatment of neurological diseases: EFNS task force on the use of intravenous immunoglobulin in treatment of neurological diseases," *Eur J Neurol*. 2009 Sep;15(9):893-908.

Indeed, several other insurance companies, including Aetna, Anthem and CIGNA, cover IVIg as a second-line treatment for PM. Aetna Clinical Policy Bulletin no 0206. http://www.aetna.com/products/rxnonmedicare/data/INJ/IVIG_2007.html. (Last accessed 3/22/10). Anthem Clinical UM Guideline IVIg. http://www.anthem.com/medicalpolicies/guidelines/gl_pw_a053678.htm. (Last accessed 3/22/10). CIGNA Coverage Policy Immune Globulin Intravenous (Human) (IGIV). Coverage Position 5026. http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/pharmacy/ph_5026_coveragepositioncriteria_Immune_Globulin_Intravenous_IGIV.pdf. (Last accessed 3/22/10).

United Healthcare goes so far as to say:

Immune globulin is PROVEN for the following:

Autoimmune Diseases

Autoimmune uveitis

Dermatomyositis and Polymyositis

United Healthcare Drug Policy Immune Globulin (IVIG) Effective 11/19/2009.

<<https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en->

[US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Drug%20Policies/IVIg_policy.pdf](#)> (Last accessed 5/20/10). Thus, the majority of insurers agree that IVIg is an important tool in a clinician's arsenal in combating the devastating effects of PM.

III. CONCLUSION

There is ample medical literature upon which to base the use of IVIg for PM. All alternatives present significant risks that are not present with IVIg. This is a previously healthy and active 30 year old woman whose physical condition is slipping away. Her doctor believes that she should be treated with IVIg.

There is real urgency here. Dr. Myo fears that Ms. Ms. Patient could develop total paralysis or need to be placed on a respirator without treatment. Corticosteroids have been tried and are not helping. Methotrexate caused lung damage. Imuran is no longer working. Therefore, the safest alternative is IVIg.

Without effective treatment, Ms. Patient's medical bills for a respirator, rehabilitation, physical therapy, and other needs will skyrocket far beyond the cost of IVIg. Thus, it is in both Wonting's interest and Ms. Patient's to try IVIg therapy.

For all of these reasons, we urge you to reverse Wonting's noncoverage decision and give this young woman a chance at the safe and effective treatment that her treating physician deems most appropriate.

Of course, if you would like any additional information, please do not hesitate to contact me. Thank you.

Sincerely,

Representative of Patient