

### How Do You Balance Treatment for an Immune Deficiency with Treatment for Cancer?

What is the balance between treating lupus by calming down the immune system with methotrexate and stimulating the immune system with intravenous immune globulin (IVIG) treatments, especially for patients with combined immunodeficiency disorder and cancer (thymoma), leading to Good syndrome with thymoma, and lupus?

**Abbie:** I spoke with Terry O. Harville, MD, PhD, medical director of the Special Immunology Laboratory at the University of Arkansas for Medical Sciences, and he said the concept of low immunity for immunodeficiency and high immunity for autoimmunity is not totally correct. We now know of approximately 500 genes that can cause immunodeficiency and autoimmunity or that may cause both in the same person. Therefore, we now consider this as dysfunctional or disordered immunity. Indeed, there are so-called gain-of-function disorders of immunity (what may be called high immunity) that result in immunodeficiency, which can be improved by prescribing medications that are typically considered immunosuppressive. Therefore, each patient and condition have to be considered and evaluated individually to provide the most appropriate therapy.

According to Dr. Harville, the use of immunosuppressive medications in someone who is immunodeficient can result in greater susceptibility to infections. Methotrexate at the typical dose of 10 mg to 15 mg a week is not truly immunosuppressive but rather anti-inflammatory.

Adding thymoma to the mixture does complicate the situation, he explains. In general, excess thymic tissue is surgically removed. Since B lymphocyte malignancy and antibody deficiency tend to be present, treatment of the B lymphocyte malignancy tends to be useful and not problematic since IVIG is typically used.

If a patient also has lupus, the therapies for that B lymphocyte malignancy (i.e., rituximab) is also very helpful. The strategy should be to maximize the use of a medication such as rituximab, along with a higher than the lowest typical dose of IVIG. This focuses the treatment against the removal of B lymphocytes, which can then be effectively treated with appropriate doses of IVIG.

### What Types of Medicare Policies Cover Hizentra in the Home for CIDP?

I was diagnosed with chronic inflammatory demyelinating polyneuropathy (CIDP) in 2015, and I am retiring at the end of this month (I am a primary care physician) and transitioning to Medicare. I am in the 10 percent of patients who still require “booster” infusions of intravenous immune globulin (IVIG) approximately every 10 weeks, even though I transitioned to self-administered weekly subcutaneous IG (Hizentra) in 2019.

I have worked with a consultant who states the IVIG infusions will be much better covered at an infusion center billed through Parts B and C rather than trying to have it covered as a home infusion through Part D. Additionally, Hizentra is also covered by Parts B and C, but are the associated supplies for this diagnosis covered as well?

**Abbie:** I spoke with Leslie Vaughan, RPh, CSP, IgCP, chief operations officer at Nufactor, a specialty infusion company, who said periodic IVIG would not be covered by Medicare Part B at home but would most likely be covered in an outpatient infusion center. Part B will pay 80 percent, and a supplemental policy will pick up the remaining 20 percent. Part D (with authorization) would cover Hizentra at home, but a Part D patient share of the cost would apply.

Hizentra is covered by Part B for CIDP at home. There is payment for supplies and the pump, as well as for nursing when supplied by a home infusion therapy provider when the nurse is in the home. Unfortunately, few specialists are accepting new Part B patients due to poor reimbursement, especially since sequestration has been reinstated.

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