Immune Deficiency Foundation Medical Advisory Committee Resolution: The danger posed by the arbitrary insurer requirement for a diagnostic vaccine challenge for all previously diagnosed individuals with Common Variable Immunodeficiency (CVID)

January 27, 2016

The Immune Deficiency Foundation (IDF) and its Medical Advisory Committee are extremely concerned about any therapeutic guidelines that are not consistent with the standard of care. We are especially troubled by a recent trend among health insurers to require patients with an established diagnosis of antibody deficiency to present evidence that they have failed to produce antibody after vaccine challenge, even if their diagnosis was established years earlier. IDF supports this vaccine challenge requirement for newly diagnosed patients with IgG levels greater than 200 mg/dl, but not for individuals already receiving immunoglobulin (Ig) replacement therapy. This is because without this evidence approval for continued Ig therapy is denied and patients are forced to stop treatment to perform the required assessment that will take several months using current standard approaches. The implementation of these requirements for patients to qualify for continued Ig therapy potentially poses a serious health threat to these patients with primary immunodeficiency diseases.

For many years, hypogammaglobulinemia with a history of recurrent invasive bacterial infections often leading to significant respiratory and/or other organ damage was the accepted diagnostic standard, depending on the age of onset, for congenital or acquired hypogammaglobulinemia. Later these disorders were merged and called common variable immunodeficiency (CVID). Our primary concern with these new guidelines is the requirement that long-term patients with CVID must provide data that confirms their diagnosis as defined by current diagnostic standards. Current diagnostic standards do not automatically invalidate past diagnoses. Furthermore, original records from years ago are likely not available even if vaccine testing was done.

Individuals with antibody deficiency already receiving Ig therapy (sometimes for decades) will have normal levels of anti-tetanus and anti-pneumococcal polysaccharide antibodies supplied by their infused Ig. The only practical way to evaluate their ability to respond to vaccine challenge is to stop their Ig therapy for 4-6 months to allow the infused Ig to be catabolized. They can then be vaccinated, wait the additional 4-6 weeks that would be required for a person with normal immunity to produce antibodies and then have their post-vaccination serum sample obtained for antibody measurement. Therefore, this process could require these often very fragile patients to be without their life-saving Ig therapy for 6-8 months or longer, all the while assuming the unnecessary and unacceptable risk of serious or even life-threatening infections that would be prevented by the Ig treatment.

A required delay or recess in therapy for 6 months or longer for vaccine challenge testing is not consistent with current standards of care as established by the American Academy of Allergy, Asthma & Immunology (AAAAI) and the American College of Allergy, Asthma & Immunology (ACAAI). Arbitrarily stopping Ig replacement therapy in an antibody deficient patient is potentially a very dangerous and reckless gamble because their first infection could be a severe or even fatal episode of invasive pneumonia, meningitis, sepsis or enteroviral meningoencephalitis. There is no medical justification to support this arbitrary exposure of previously diagnosed patients with CVID to the risk of serious infections and their attendant complications.

Review of a patient's clinical history for meaningful infections, the available laboratory, genetic and imaging studies, along with physical evidence of end-organ damage from recurrent infections and the favorable effect of Ig replacement on clinical course should be sufficient to validate an antibody deficiency diagnosis for the large majority of cases. In those few individuals with unclear diagnoses, Board Certified immunologists are professionally qualified to evaluate the presence of appropriate indications for Ig replacement therapy and to determine whether it is necessary to stop therapy to perform further testing in an individual patient. The practice of insurers arbitrarily mandating that all established patients carrying a diagnosis of CVID must risk their health and well being to submit evidence of vaccine non-responsiveness is both unnecessary and unjustified.