The Clinical Immunology Society (CIS) stands in strong support of the autonomy of the physician-patient relationship to allow individualized decisions to be made on the optimal delivery route of immunoglobulin therapy to patients with primary immunodeficiency (PI). The decision for a patient with PI to be on either subcutaneous immunoglobulin (SCIG) or intravenous immunoglobulin (IVIG) depends on many factors. The CIS strongly advocates that the decision of route of administration should be patient specific and made via shared decision making between the patient and their immunologist.

We are deeply concerned by the recent decision by some commercial health insurers to discontinue coverage for subcutaneous immunoglobulin (SCIG) therapy and require patients to transition to a covered intravenous immunoglobulin (IVIG) replacement option to be administered in a physician office, freestanding infusion center, home or other approved location. While long term efficacy of SCIG vs IVIG in preventing life threatening infections is generally similar, there are many other factors that play into treatment decisions. These considerations can include:

- Freedom of patient choice of route of administration is important in patient-centric treatment
- Economic impact included cost of the medication and missed days of school/work for infusions
- Side effect profile
- Pharmacokinetics
- Comorbid medical conditions
- Societal concerns including the nationwide critical nursing shortage.

Patients with a primary immunodeficiency need an immunoglobulin replacement therapy that is tailored to their specific disease state, comorbidities and personal preferences. The decision as to which route of administration is best for an individual patient should be decided between the patient and their immunologist. An insurance company failing to offer coverage for either SCIG or IVIG threatens our ability to provide the standard of care in these rare and complicated patients.

The CIS Advocacy Committee,
On Behalf of the CIS Executive Council