Immunoglobulin Database

Annual Report 2024/25

April 2026

MD/SAS

Compiled by
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1 Database Overview

Mark Foster

New National Immunoglobulin Database

Welcome to the 2024/25 Immunoglobulin Database Annual Report. This has been a landmark year for the immunoglobulin community, marked by the successful launch of the new IGD. More than a system replacement, the new platform represents a major step forward in how immunoglobulin data is recorded, managed and used to support patient care, clinical oversight and national strategy. By bringing together functions that were previously split across systems, the new IGD provides a single, more streamlined service with one login, one national patient record and one active treatment episode per patient, helping to reduce duplication, improve consistency and support safer, more efficient ways of working across trusts, panels and clinical teams.

The new IGD has been shaped by many years of user feedback, experience and challenge from across the immunoglobulin community. This is your system, and it is the result of the insight, suggestions and practical knowledge that users have shared over time about how the database should work in real-world settings. The new platform offers clearer workflows, improved access management, better visibility across organisations, stronger support for referrals and reviews, and a more modern foundation for future development. These changes have only been possible because of the commitment of users who have continued to engage constructively with the programme and help shape its direction.

The benefits for reporting are equally significant. A single national platform improves the consistency, completeness and comparability of data, providing a stronger basis for local, regional and national reporting. Better structured data, clearer episode management and improved alignment across the system support more reliable analysis of activity, demand, usage and outcomes.

The strategic purpose of the IGD remains the same as it was when it was launched, but the platform capability and operational maturity have moved on significantly, enabling the IGD to meet the demands of a more complex and data-driven environment than the one it was originally built for.

As always, the value of the IGD depends on the quality and timeliness of the data entered. Timely, accurate and disciplined data entry remains essential to ensuring that the database can continue to provide a trusted picture of immunoglobulin use and support effective decision-making across the service. We would therefore like to thank all users for their continued effort, care and professionalism in maintaining the data, and for the commitment they show for making the IGD a success.

This Annual Report brings together updates from key stakeholders and analysis of immunoglobulin usage across England and Northern Ireland for the 2024/25 financial year, providing an important overview of national activity, trends and developments.

2 Commissioning Update

Siraj Misbah

Commissioning Update

Therapeutic immunoglobulin (Ig) is a high cost drug commissioned by NHS England. It is an expensive finite resource widely used for antibody replacement and immunomodulation.

Since the last database report (2023/24), the main growth area in immunoglobulin use has been in secondary antibody deficiency, driven by the increasing use of advanced immune-mediated therapies for haematological cancer in both adults and children. These new immunotherapies comprise bispecific antibodies (also known as BiTE – Bispecific T-cell Engagers) and chimeric antigen receptor T cells directed against B-cell antigens (CAR-T). The use of bispecific antibodies and CAR-T therapies has transformed the outlook for adults and children with relapsing-refractory B-cell cancers. However, patients benefiting from these advanced immunotherapies are faced with iatrogenic on-target, off-tumour adverse effects in the form of B-cell aplasia and antibody deficiency. As a pharmacodynamic effect of therapy, these adverse effects are unavoidable.

As evidence of infection susceptibility in this group of patients evolves, it is clear that patients with myeloma receiving anti-BCMA (B-cell Maturation Antigen) targeted bi-specifics and CAR-T therapies are particularly prone to serious infections, which can be mitigated by Ig replacement. There are a number of anti-BCMA therapies that have already been licensed in myeloma (bi-specifics: elranatamab, teclistamab, linvoseltamab, CAR-T: Idecabtagene, Ciltacabtagene). For lymphoma, licensed bi-specifics targeting CD20 include Glofitamab and Epcoritamab. Long term follow up of patients suggests that there is a hierarchy of B-cell deficiency depending on the antigenic target (BCMA > CD 19/20 > GPRC5D – G protein-coupled receptor class C group 5 member D).

The risk of infection in recipients of bispecific antibodies in myeloma is such that it has been argued that all patients should be commenced on Ig replacement regardless of IgG levels[1]. This is a question that requires careful analysis of emerging data. Currently, commissioning guidance specifies an eligibility criterion of a non-paraprotein IgG level of < 4 g/l as the starting point for Ig replacement at the inception of bispecific antibody treatment, irrespective of infection burden. Any emerging substantive changes in the evidence base will determine whether current guidance should be reviewed.

The growth in Ig use in secondary antibody deficiency is summarised in the Table.

	2023/24	2024/25	Growth in use
Number of patients	3,535	4,277	20%
Grams of Ig used	952,497	1,159,254	21%

Other noteworthy areas of on-going Ig stewardship include immune thrombocytopenic purpura (ITP), where the number of patients requiring 1g/kg in 2024/25 stands at 88% (12% requiring 2g/kg), thus reversing the previously observed excessive use of 2g/kg in 45% of patients in 2014/15. This change in prescribing has delivered recurrent annual savings exceeding 1 million pounds, without compromising quality of care[2,3].

Overall, detailed evidence-based commissioning guidance has underpinned continuing Ig stewardship in England, thus ensuring appropriate use in deserving patients while avoiding its speculative use in disorders with very little or poor-quality evidence. The rigour and success of commissioning guidance can be gauged by international comparisons. The Ig clinical commissioning policy for England currently includes 44 indications (previously > 100 in 2008), as compared with Canada, which has five sets of guidelines for 25 - 165 indications[3] . This translates into per-capita use of 212g/1000 population of Ig as opposed to 120g/1000 population in England[5].

The evidence base for the use of Ig for both existing and new indications will continue to be closely monitored by the Ig Clinical Oversight group in order to ensure that commissioning guidance remains up to date.

References

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3. HaemSTAR Collaborators. A single 1 g/kg dose of intravenous immunoglobulin is a safe and effective treatment for immune thrombocytopenia; results of the first HaemSTAR ‘Flash-Mob’ retrospective study incorporating 961 patients. Br J Haematol. 2022 Jan;196(2):433-437. doi: 10.1111/bjh.17692. Epub 2021 Dec 3. PMID: 34859421.

4. Harmon, M., Riazi, K., Callum, J. et al. Immunoglobulin utilization in Canada: a comparative analysis of provincial guidelines and a scoping review of the literature. Allergy Asthma Clin Immunol 19, 85 (2023). https://doi.org/10.1186/s13223-023-00841-z

5. de Meester Christophe, Bourgeois Jolyce, Devriese Stephan, San Miguel Lorena. Polyvalent immunoglobulins – Part 2: Use in Belgium. Health Technology Assessment (HTA). Brussels. Belgian Health Care Knowledge Centre (KCE). 2020. KCE Reports 336 (Table 1, pg 14). DOI : 10.57598/R336C.

3 MPSC

Darryn Boardman

Commercial and Contracting

NHS England's Medicines Procurement and Supply Chain (MPSC) team is responsible for the tendering, contract management, and supplier management of plasma derived medicinal products (PDMPs) supplied to the NHS through centrally procured contracts and Framework agreements.

Immunoglobulin (Ig) is supplied to NHS hospitals by medicine manufacturers under two contracted agreements, the Human Normal Immunoglobulin & Anti-D Immunoglobulin Framework and the UK Plasma for Medicines (UK PfM) contract.

These agreements provide a regulatory-compliant route for NHS hospitals to purchase essential medicines without the need to complete their own tenders and contract manage product supply and allocations, supporting clinical standardisation, supply stability and value for money.

The Human Normal Immunoglobulin & Anti-D Immunoglobulin Framework, covering England, Northern Ireland and Scotland, commenced on 1 April 2025 and will be in place until 31 December 2027, with options to extend the framework until a latest date of 31 March 2029.

The UK PfM contract, covering England, Northern Ireland, Wales and Scotland commenced on 1 February 2025 and will be in place until 30 January 2030, with options to extend the contract until a latest date of 30 January 2032.

These agreements provide hospitals with access to 10 brands of intravenous, subcutaneous and facilitated subcutaneous Ig supplied by three contracted suppliers.

Supply and Resilience

The availability of Ig has been subject to sustained global pressure over many years, reflecting the inherent vulnerabilities of plasma-derived medicinal products (PDMPs). International experience has demonstrated that Ig supply is highly sensitive to fluctuations in plasma donations, the long and complex fractionation process, and rapid growth in global demand driven by expanding clinical indications. These risks were further exacerbated by the COVID-19 pandemic, during which reductions in plasma collection and disruption to international supply chains contributed to widespread and prolonged shortages across the world. International regulators and professional bodies have consistently highlighted that unexpected increases in demand cannot be met quickly, given the extended lead times required to convert plasma into finished products, leaving health systems and patients exposed to supply vulnerability.

Against this backdrop, the launch of the new Human Normal & Anti-D Immunoglobulin Framework and the UK PfM contract strengthens resilience within the NHS's commercial and supply arrangements. Both agreements have been designed to address inherent supply fragility by reinforcing supplier expectations and moving toward more proactive supply management.

A central feature of this approach is the introduction of defined contractual commitments requiring suppliers to hold a minimum of three months of buffer stock within the UK for each awarded brand, with suppliers holding six months of certain brands. These requirements, written into the contract terms, provide the NHS with a robust volume of product held in country, enabling continuity of supply during periods of international disruption, manufacturing delays or sudden demand spikes. This represents a significant enhancement compared with previous arrangements, under which the NHS was more exposed to upstream global shocks and constrained by limited visibility of supplier stock positions.

Resilience has been further reinforced through the UK Plasma for Medicines programme, which supports the reintroduction of UK-derived plasma into the supply chain. By diversifying plasma sourcing and reducing dependence on international plasma markets, this programme strengthens national self-sufficiency and mitigates risks associated with global plasma shortages, regulatory changes or geopolitical disruption.

In parallel, previous product restrictions have been removed, enabling hospitals to access a range of clinically appropriate products and improving access for increased demand in growing therapy areas.

To support equitable utilisation of awarded product supply, regional and Trust-level allocations have been implemented, aligned to contractually awarded volumes. MPSC provides national oversight of additional demand requests in collaboration with suppliers and regional pharmacy and commissioning teams.

MPSC continues to work proactively with industry partners, clinicians and system stakeholders to monitor supply risk, explore innovation, and identify further opportunities to strengthen long-term resilience within the category, ensuring continuity of care for patients who rely on these essential medicines.

UK Plasma Programme

Since the launch of the UK PfM programme, in early 2025, NHS England has delivered measurable patient benefits by re-introducing UK plasma-derived medicines into routine NHS supply for the first time in decades, strengthening resilience for patients reliant on Ig.

Through NHS England's national commercial and commissioning leadership, UK plasma-derived Ig has been successfully introduced into NHS clinical practice for the first time in more than 25 years. As at the first anniversary of the programme, over 3,000 patients have received UK plasma-derived Ig, including around 1,500 patients with long-term, chronic conditions requiring ongoing treatment. This represents a significant step change in supply security for patients who depend on uninterrupted access to life-saving treatment.

By enabling UK-sourced plasma medicines to reach front line services rapidly, NHS England has reduced NHS exposure to the volatility of global plasma markets, which have historically been associated with shortages, allocation restrictions and resultant burden for clinical teams and anxiety for patients.

Importantly, the availability of UK-derived product alongside imported supply has increased overall system flexibility, supporting continuity of care and significantly reducing the risk of treatment delays or enforced product switching for clinically vulnerable patients.

Commercially, MPSC has delivered increased supply stability and risk reduction through the UK Plasma for Medicines contract. From 1st April to 31st December 2025, UK-plasma derived Ig accounted for approximately 20% of total Ig volume supplied to the NHS in England. This represents a substantial reduction in reliance on global plasma within the first nine months of the programme.

By securing a long-term contract for UK plasma-derived Ig and integrating these medicines into national procurement frameworks and allocation processes, MPSC has strengthened the resilience of the category. This approach improves predictability of supply, enhances national self-sufficiency, and reduces exposure to international market pressures such as fluctuating plasma donation rates, manufacturing constraints and geopolitical risk.

Contacting MPSC

For further information, please contact MPSC at: karen.bell7@nhs.net or darryn.boardman@nhs.net

4 Blood Transfusion Service

Gerard Gogarty

Plasma for Medicines in England

In August 2024, NHS Blood and Transplant (NHSBT) began supplying plasma for fractionation to their toll fractionation partner, Octapharma. In England, the first supply of medicines, Gamten (Immunoglobulin) and Octalbin (Albumin) were distributed to NHS hospitals in March 2025.

NHSBT has been working with partners with the aim of delivering a programme to build national self-sufficiency in plasma derived medicines. The Department of Health and Social Care has been leading on policy, with NHS England focusing on fractionator procurement and the distribution of medicines to the NHS. NHSBT's role is to leverage its unique infrastructure and specialist capabilities to collect, process and supply plasma for fractionation. Plasma is collected through two methods: the recovery of plasma from whole blood donations (known as recovered plasma) and via plasmapheresis at dedicated centres in Birmingham, Reading and Twickenham (known as source plasma).

Following a significant ramp up in processing capacity in 2024, NHSBT was able to recover plasma from whole blood donations (excluding the requirement for transfused products). In 24/25 we collected over 301,000 litres of plasma with an aim of increasing this to 320,000 litres by the end of March 2026. We realised our ambition of around 23% self-sufficiency in immunoglobulin and 80% in albumin in March 2025.

To deliver further increases in immunoglobulin self-sufficiency, NHSBT is collaborating with the Department of Health and NHS England to explore how further growth in self-sufficiency can be delivered, which will include the need to increase the number of locations where source plasma is collected.

5 2024/25 Reports

Mark Foster

Table 1.1 Immunology - volume of recorded immunoglobulin and patients on Ig therapy 2024/25

Condition	Patients	Grams
Primary immunodeficiencies (PID) / (IEI) associated with significant antibody defects (excluding specific antibody deficiency)	3,459	1,266,481
Secondary antibody deficiencies	3,882	1,057,955
Specific antibody deficiency	271	95,695
Thymoma with immunodeficiency	59	21,782
Haematopoeitic stem cell transplantation (HSCT) in primary immunodeficiencies (PID) / (IEI)	97	9,857
Total	7,741	2,443,086

Table 1.2 Haematology - volume of recorded immunoglobulin and patients on Ig therapy 2024/25

Condition	Patients	Grams
Immune thrombocytopenic purpura (ITP)	1,483	169,885
Autoimmune haemolytic anaemia	190	22,423
Alloimmune thrombocytopenia	37	17,156
Post-transfusion hyperhaemolysis	91	16,178
Coagulation factor inhibitors (alloantibodies and autoantibodies)	46	14,330
Haemophagocytic syndrome / Haemophagocytic lymphohistiocytosis (HLH)	117	13,780
Acquired red cell aplasia associated with chronic parvovirus B19 infection	80	8,955
Haemolytic disease of the newborn	146	1,118
Post-transfusion purpura	<=10	180
Total	2,191	264,004

Table 1.3 Neurology - volume of recorded immunoglobulin and patients on Ig therapy 2024/25

Condition	Patients	Grams
CIDP (including IgG or IgA associated paraprotein associated demyelinating neuropathy)	1,711	1,527,946
Multifocal motor neuropathy - (MMN)	694	746,321
Inflammatory myopathies	518	238,614
Myasthenia gravis	899	213,599
Guillain–Barré syndrome and variants	953	136,142
Stiff person syndrome - (SPS) or variant	132	77,734
Autoimmune encephalitides (AIE)	214	44,021
IgM Paraprotein-associated demyelinating neuropathy	26	16,898
Non-MS CNS inflammatory disease - ACUTE disease	84	15,736
Non-MS CNS inflammatory disease; CHRONIC relapse prevention	21	10,187
Paraneoplastic neurological syndromes (PNS) without evidence of autoantibodies	33	6,535
Opsoclonus-myoclonus syndrome	23	4,701
Rasmussens Encephalitis	<=10	4,394
Neuromyotonia (Isaacs syndrome)	<=10	2,305
Acute idiopathic / autoimmune dysautonomia /ganglionopathy	<=10	1,660
Total	5,338	3,046,792

Table 1.4 Infectious diseases - volume of recorded immunoglobulin and patients on Ig therapy 2024/25

Condition	Patients	Grams
Toxic Shock Syndrome (TSS)	358	35,706
Viral pneumonitis post-transplantation	39	3,439
Post-exposure prophylaxis or treatment of viral or pathogenic infection, in line with Public Health England recommendations	24	2,057
Severe or recurrent Clostridium difficile infection (CDI) colitis	46	1,381
Measles	147	783
Tetanus	12	482
Hepatitis A	12	90
Varicella zoster	<=10	17
Total	641	43,953

Table 1.5 'Others' - volume of recorded immunoglobulin and patients on Ig therapy 2024/25

Condition	Patients	Grams
Immunobullous diseases	37	19,693
Kawasaki disease	400	16,131
ANCA-associated systemic vasculitides	37	15,697
Transplantation (Solid Organ)	121	15,046
Autoimmune uveitis	6	1,915
Catastrophic antiphospolipid syndrome	14	1,630
Paediatric inflammatory multisystem syndrome temporally associated to COVID-19 (PIMS-TS)	<=10	1,140
Gestational allo-immune Liver Disease (GALD)	<=10	180
Allo-immune neonatal haemochromatosis	<=10	40
Total	629	71,471

Table 1.6 Non-commissioned - volume of recorded immunoglobulin and patients on Ig therapy 2024/25

Condition	Patients	Grams
Non-commissioned indications	253	94,670
Total	253	94,670

Please note - patients may appear in more than one specialty where treatment spans multiple specialties; specialty patient totals should therefore not be summed to derive a national deduplicated patient total.

Figure 1.1 Yearly number of patients on immunoglobulin therapy 2017/18 - 2024/25

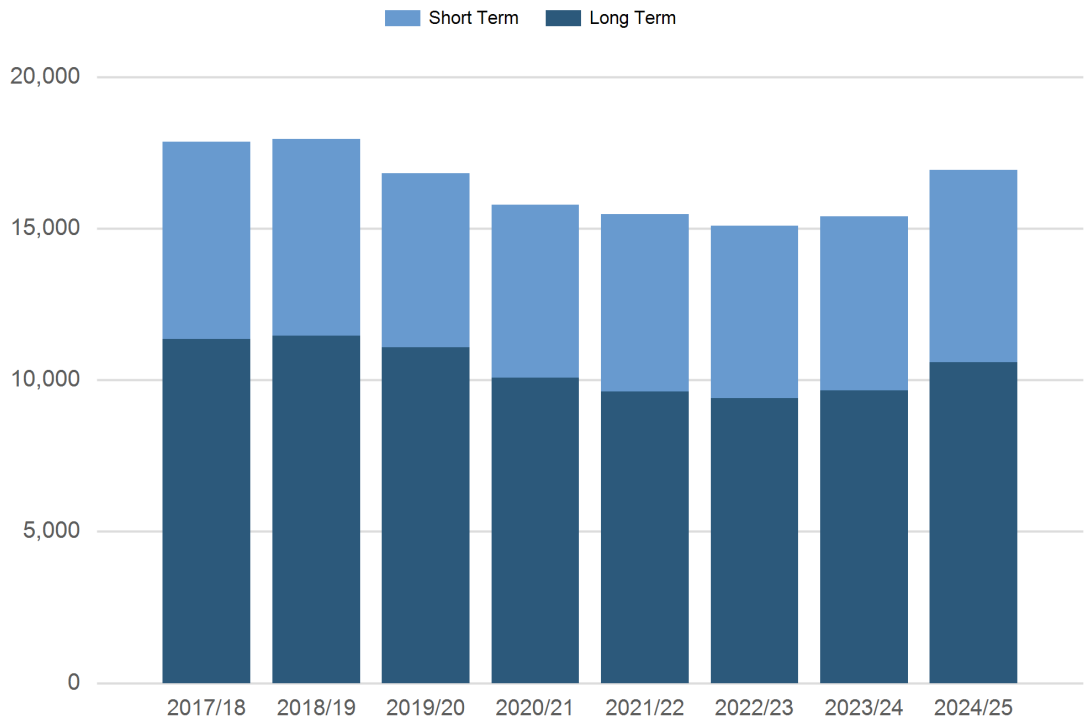

Figure 1.2 Yearly number of patients on immunoglobulin therapy by speciality 2017/18 - 2024/25

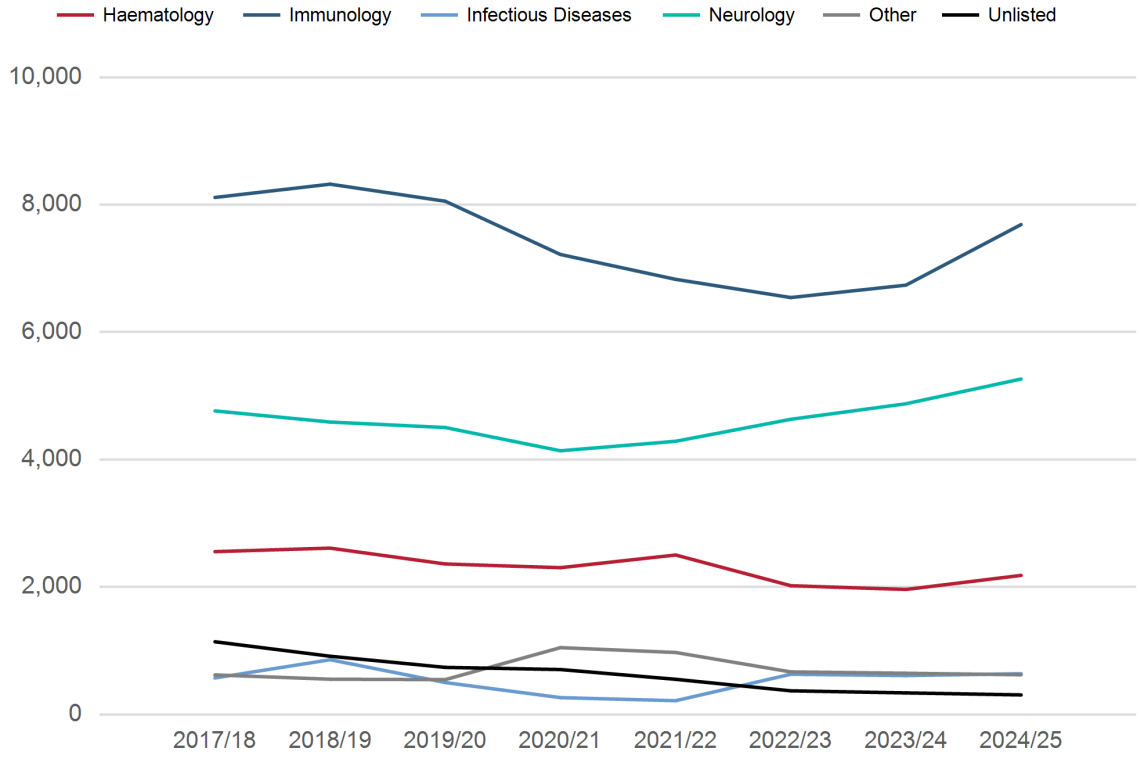

Figure 1.5 Number of patients on immunoglobulin therapy by commissioning region 2024/25

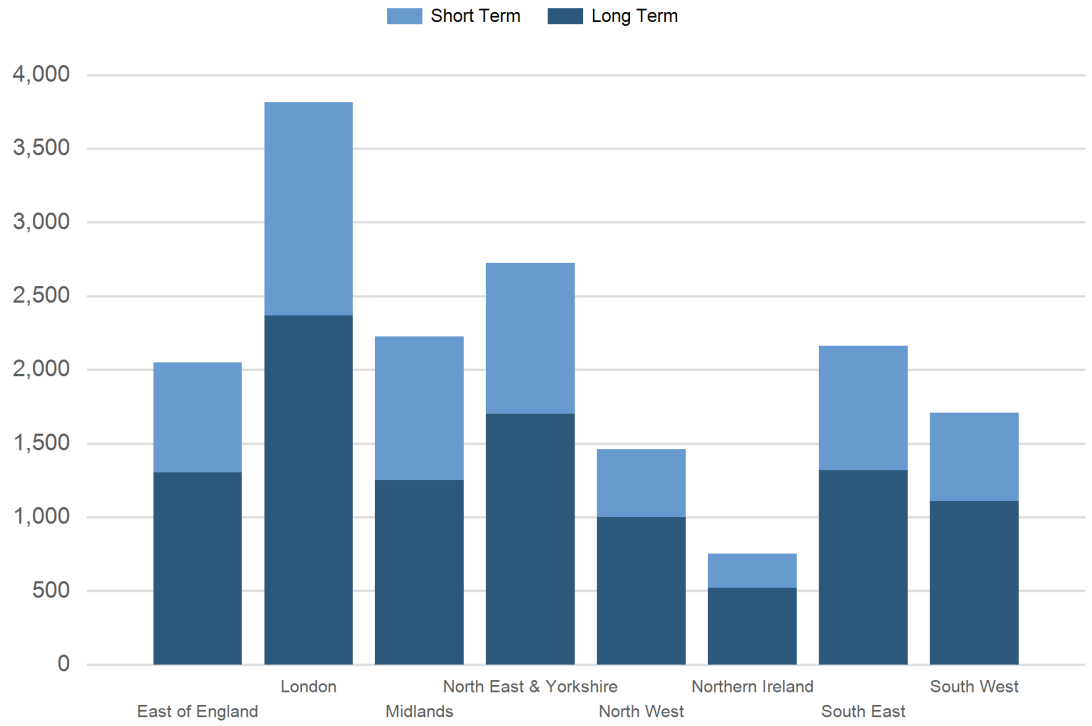

Figure 1.6 Recorded volumes of immunoglobulin by commissioning region 2024/25

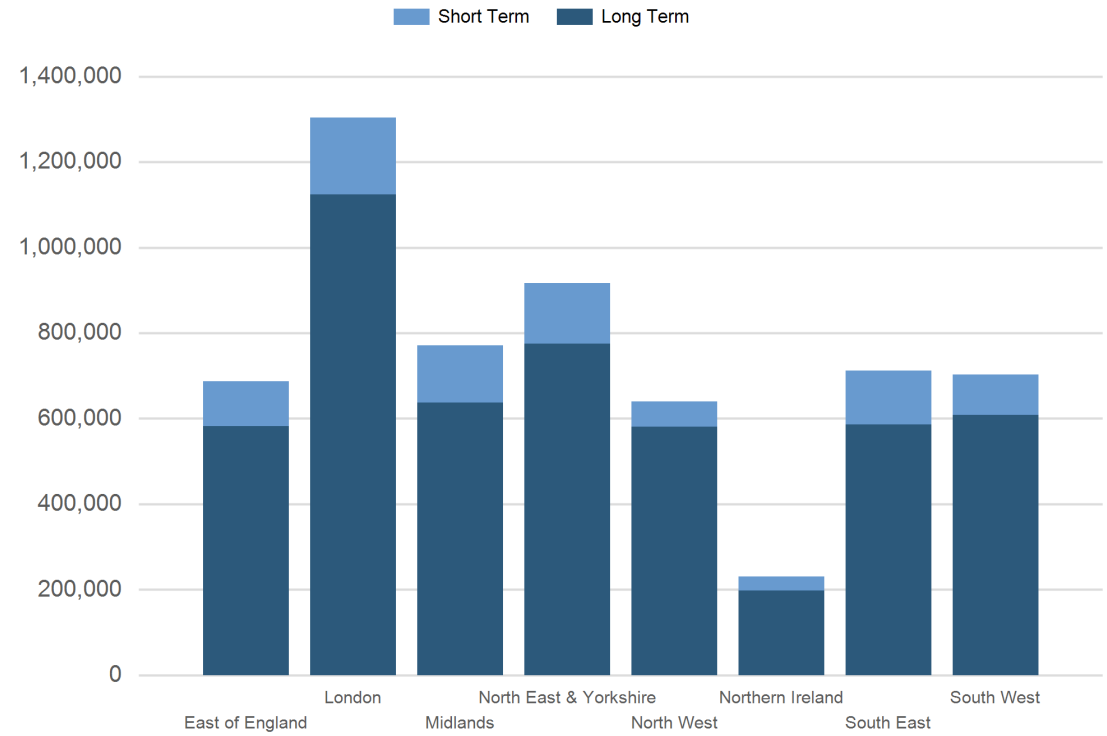

Table 2.1 Recorded volumes of immunoglobulin and patients on Ig therapy by SRIAP 2024/25

Region	Panel	Volume (g)	Patients
N.Ireland	Belfast	231,061	744
N.Ireland Total		231,061	744
London	North Central London	658,226	1,635
	North East London	253,710	677
	North West London	174,402	739
	South London	250,916	867
London Total		1,337,254	3,918
Midlands & East	Central / South West Midlands	274,434	657
	East Midlands	339,030	967
	East of England	646,137	1,855
	North / West Midlands	153,596	505
Midlands & East Total		1,413,196	3,984
North	Cheshire & Mersey	186,907	392
	Greater Manchester - Salford	273,914	430
	Greater Manchester & Lancs	178,633	620
	Humber, Coast & Vale	103,756	320
	North & West Yorkshire	273,133	868
	North East & Cumbria	355,304	986
	South Yorkshire	184,007	525
North Total		1,555,652	4,141
South	Kent & Medway	93,011	323
	Peninsula	246,265	531
	South West	330,200	924
	Southampton/Hampshire	325,155	866
	Sussex & Surrey	263,412	704
	Thames Valley	168,772	574
South Total		1,426,814	3,922
Total		5,963,976	16,709

Table 2.2 Recorded volume of immunoglobulin and patients on Ig therapy in the top 50 Trusts 2024/25

Trust	Volume (g)	Patients
Cambridge University Hospitals NHS Foundation Trust	327,145	790
University College London Hospitals NHS Foundation Trust	292,030	455
Royal Free London NHS Foundation Trust	277,801	688
Salford Royal NHS Foundation Trust	268,359	401
Belfast Health and Social Care Trust	231,061	744
Barts Health NHS Trust	223,953	554
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	204,569	489
University Hospitals Birmingham NHS Foundation Trust	201,334	374
Leeds Teaching Hospitals NHS Trust	184,854	575
Sheffield Teaching Hospitals NHS Foundation Trust	158,404	345
The Walton Centre NHS Foundation Trust	144,549	141
North Bristol NHS Trust	144,063	292
University Hospital Southampton NHS Foundation Trust	138,880	450
Oxford University Hospitals NHS Foundation Trust	135,634	382
University Hospitals of Leicester NHS Trust	129,483	303
St Georges University Hospitals NHS Foundation Trust	113,770	230
Nottingham University Hospitals NHS Trust	110,713	365
University Hospitals Plymouth NHS Trust	98,701	284
Kings College Hospital NHS Foundation Trust	93,202	350
Imperial College Healthcare NHS Trust	78,555	272
Brighton and Sussex University Hospitals NHS Trust	77,275	160
Lancashire Teaching Hospitals NHS Foundation Trust	76,729	123
Royal Cornwall Hospitals NHS Trust	75,480	109
South Tees Hospitals NHS Foundation Trust	72,225	156
Hull University Teaching Hospitals NHS Trust	68,036	190

Table 2.2 Recorded volume of immunoglobulin and patients on Ig therapy in the top 50 Trusts 2024/25

Trust	Volume (g)	Patients
East Suffolk and North Essex NHS Foundation Trust	66,885	191
University Hospitals of North Midlands NHS Trust	64,932	189
Frimley Health NHS Foundation Trust	51,007	166
Gloucestershire Hospitals NHS Foundation Trust	50,582	136
Norfolk and Norwich University Hospitals NHS Foundation Trust	48,616	118
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	45,545	133
University Hospitals of Derby and Burton NHS Foundation Trust	45,425	139
Royal United Hospitals Bath NHS Foundation Trust	44,746	124
Great Ormond Street Hospital for Children NHS Foundation Trust	43,653	275
East Sussex Healthcare NHS Trust	42,035	99
Royal Surrey County Hospital NHS Foundation Trust	39,326	107
Somerset NHS Foundation Trust	36,042	96
Maidstone and Tunbridge Wells NHS Trust	35,251	132
Royal Brompton & Harefield NHS Foundation Trust	34,133	87
University Hospitals Bristol & Weston	32,738	225
East Kent Hospitals University NHS Foundation Trust	32,650	72
Mid Yorkshire Hospitals NHS Trust	32,411	89
The Royal Wolverhampton NHS Trust	32,221	75
The Royal Marsden NHS Foundation Trust	31,950	167
University Hospitals Coventry and Warwickshire NHS Trust	31,428	101
Mid Essex Hospital Services NHS Trust	31,292	104
Royal Devon and Exeter NHS Foundation Trust	29,347	92
Western Sussex Hospitals NHS Foundation Trust	28,190	77
Southend University Hospital NHS Foundation Trust	28,043	79
Hampshire Hospitals NHS Foundation Trust	27,320	83

Figure 2.1 Monthly recorded volume of immunoglobulin by regime 2024/25

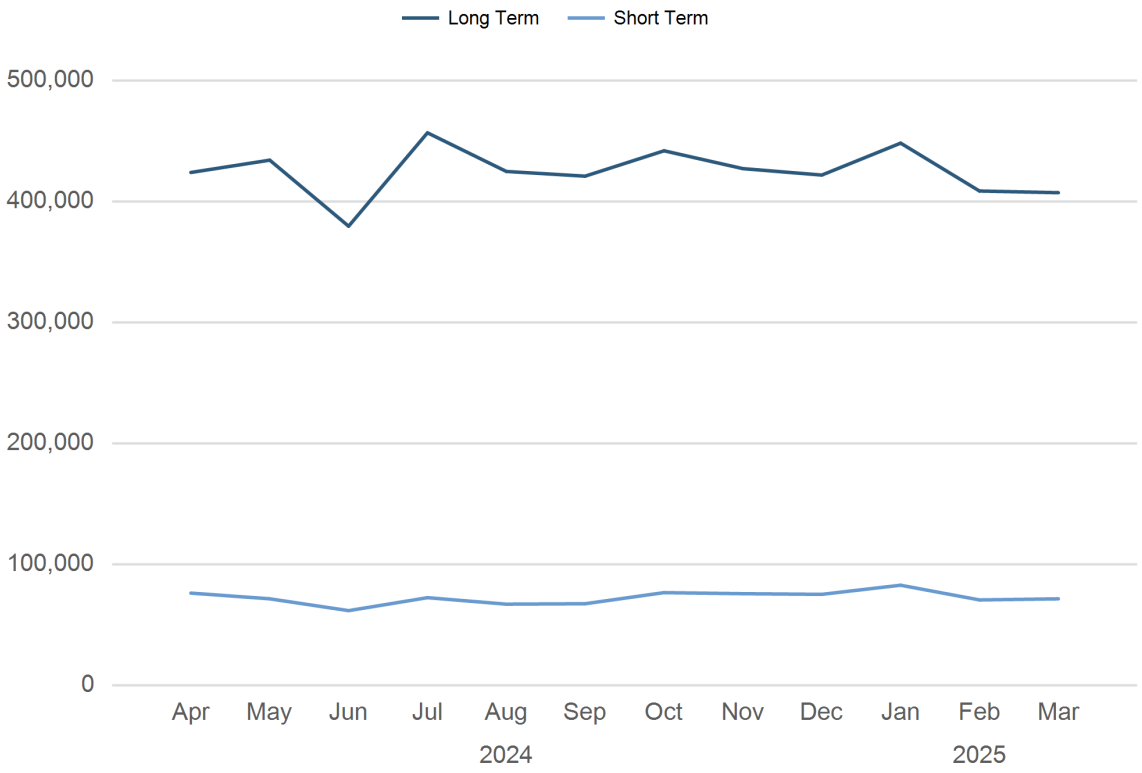

Figure 2.2 Yearly recorded volume of immunoglobulin by regime 2017/18 - 2024/25

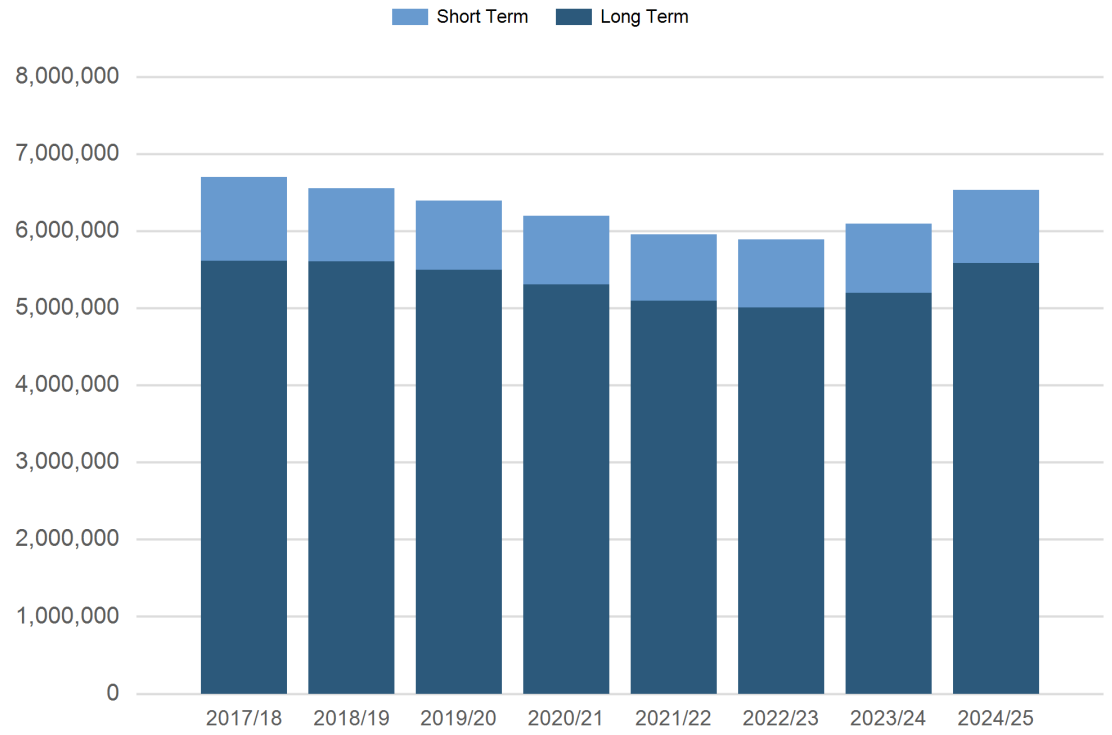

Figure 2.3 Monthly recorded volume of immunoglobulin by speciality 2024/25

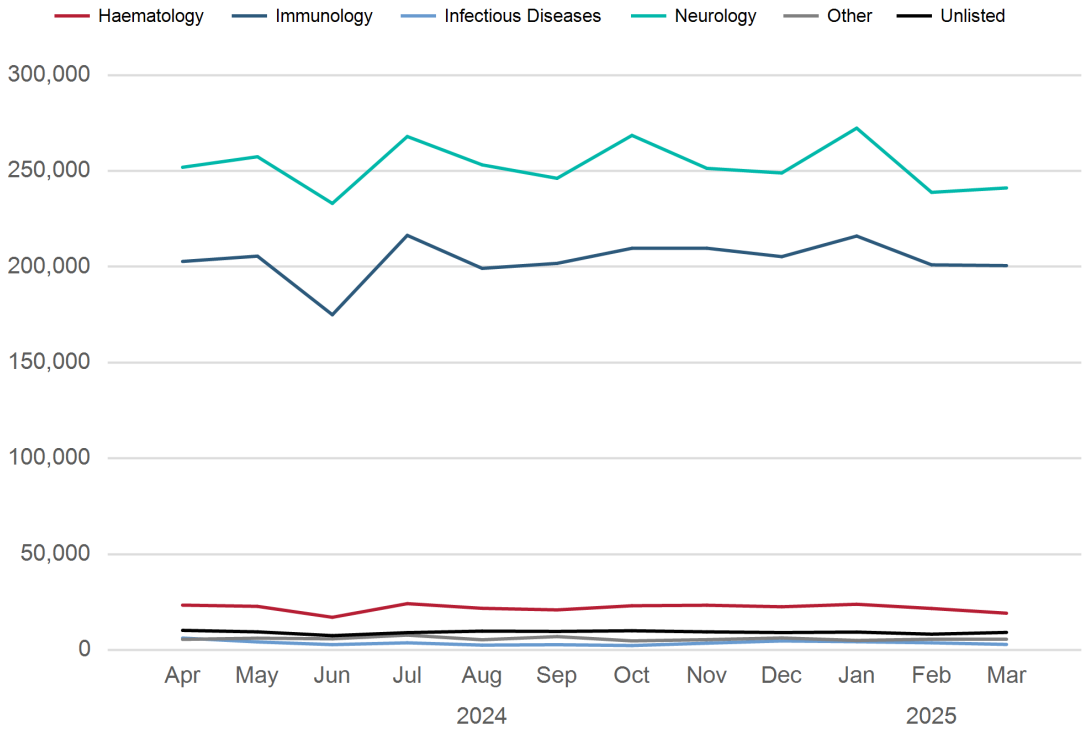

Figure 2.4 Yearly recorded volume of immunoglobulin by speciality 2017/18 - 2024/25

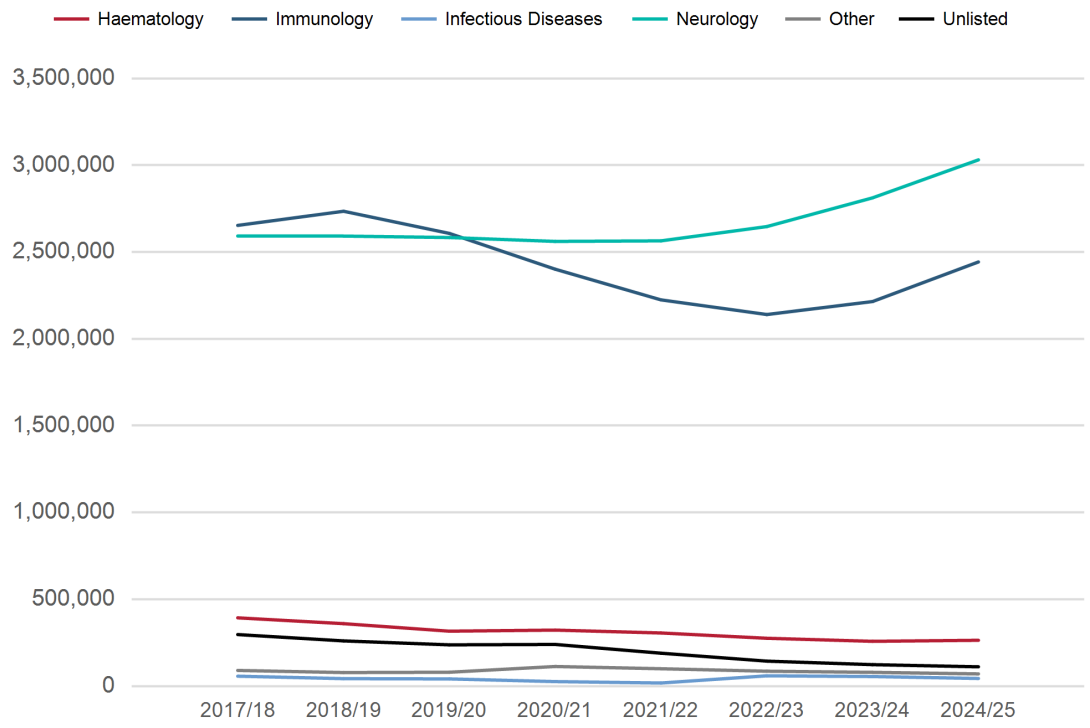

Table 3.1 Recorded volumes of immunoglobulin by supplier & brand 2024/25

Product Type	Supplier	Brand	Long Term	Short Term	Total
Intravenous			3,675,742	858,147	4,533,889
	BPL	Gammaplex 10%	69,110	31,903	101,013
	CSL	Privigen 10%	1,950,517	471,202	2,421,719
	Grifols	Flebogamma DIF 5%	128,186	6,253	134,439
		Gamunex 10%	303,174	72,595	375,769
		Intratect 10%	343,853	68,690	412,543
		Intratect 5%	46,690	13,520	60,210
	LFB	Iqymune 10%	186,550	12,243	198,793
	Octapharma	Gamten 10%	6,840	2,525	9,365
		Octagam 10%	400,474	54,988	455,462
		Octagam 5%	17,580	1,940	19,520
		Panzyga 10%	1,300	2,540	3,840
	Takeda	Kiovig 10%	221,468	119,749	341,217
Sub-cutaneous			1,419,006	11,082	1,430,088
	BPL	Subgam	38,034	114	38,148
	CSL	Hizentra 20%	538,810	5,623	544,433
	Grifols	Xembify	2,571	16	2,587
	Octapharma	Cutaquig 16.5%	252,740	2,159	254,899
	Takeda	Cuvitru	462,698	2,610	465,308
		HyQvia	124,153	560	124,713
Total			5,094,748	869,229	5,963,976

Figure 3.1.1 Monthly number of patients on IV and SC immunoglobulin therapy 2024/25

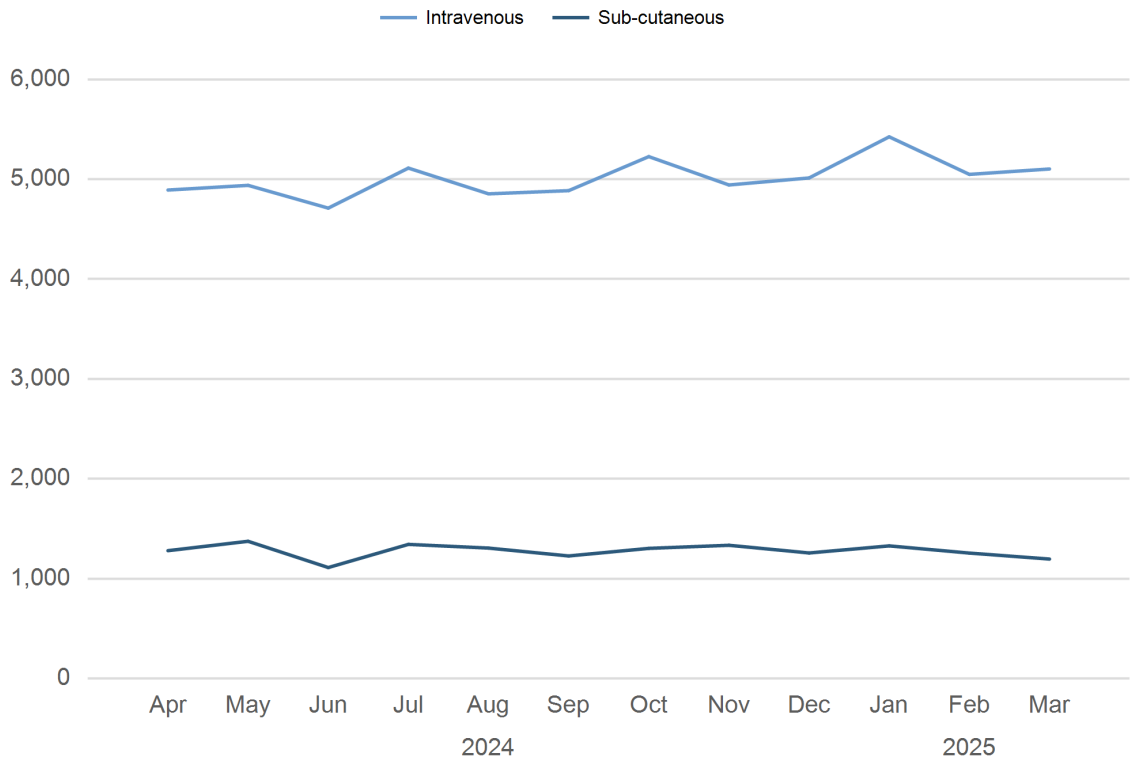

Figure 3.1.2 Yearly number of patients on IV and SC immunoglobulin therapy 2017/18 - 2024/25

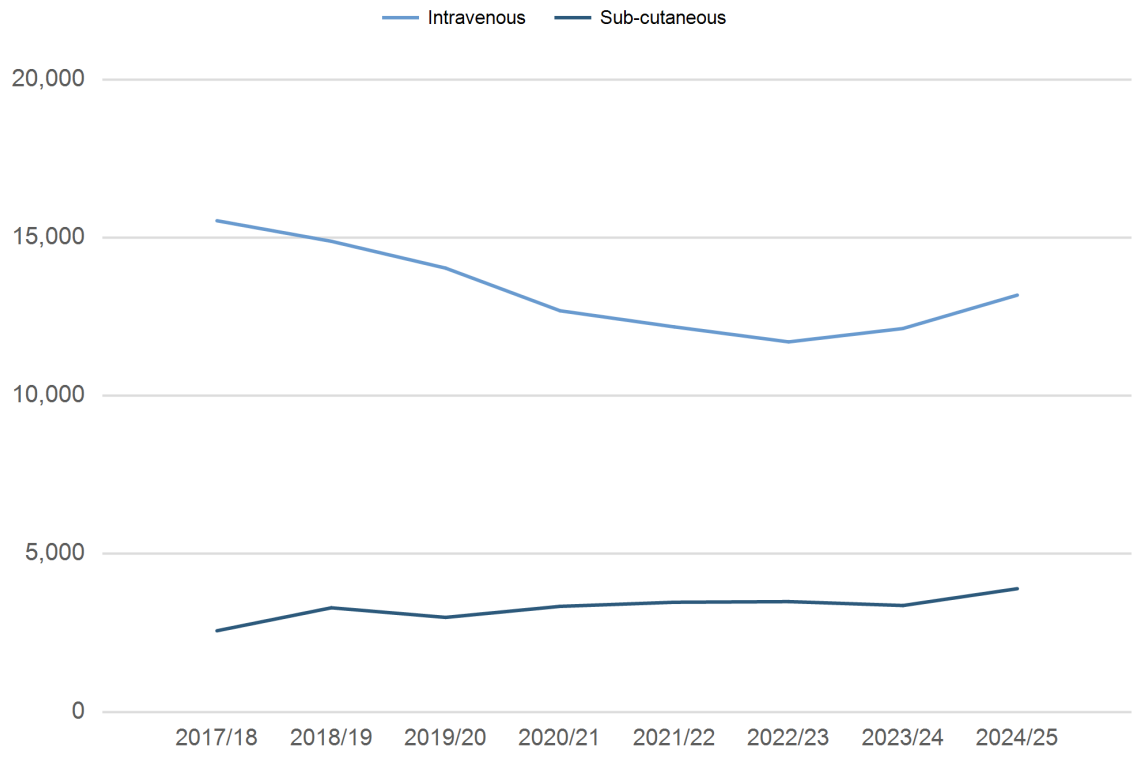

Figure 3.2.1 Monthly recorded volume of IV and SC immunoglobulin 2024/25

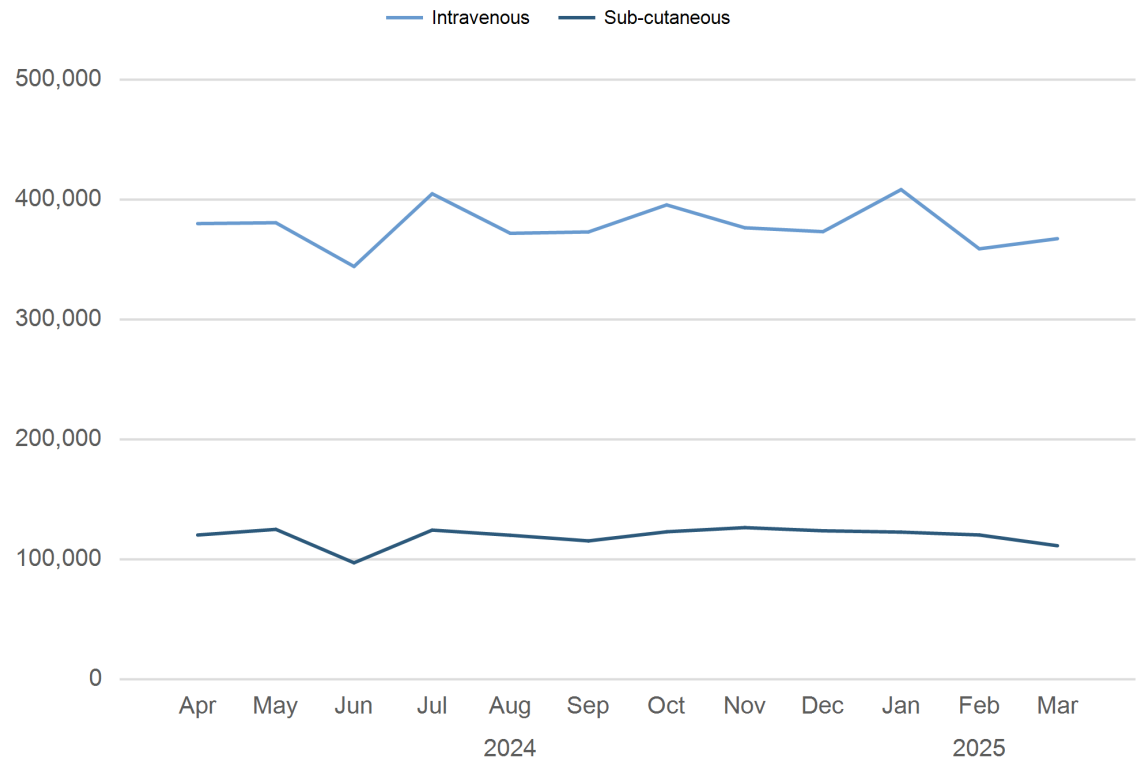

Figure 3.2.2 Yearly recorded volume of IV and SC immunoglobulin 2017/18 - 2024/25

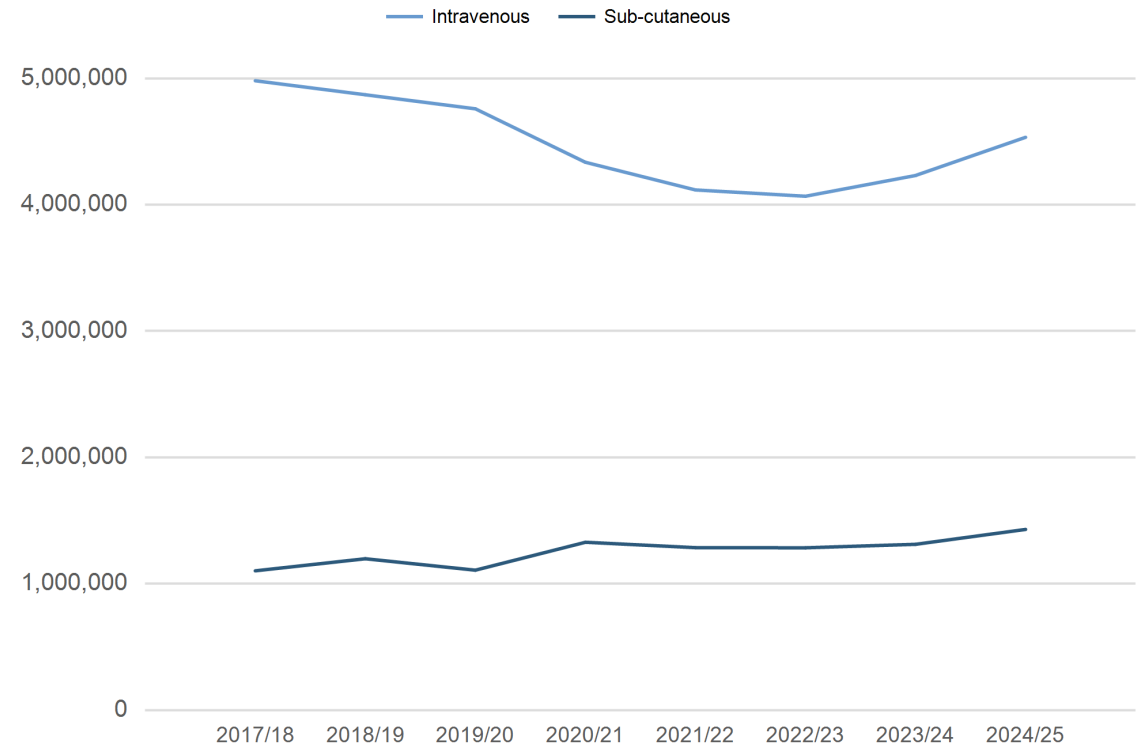

Figure 3.3.1 Monthly recorded volume of 10% IV immunoglobulin products 2024/25

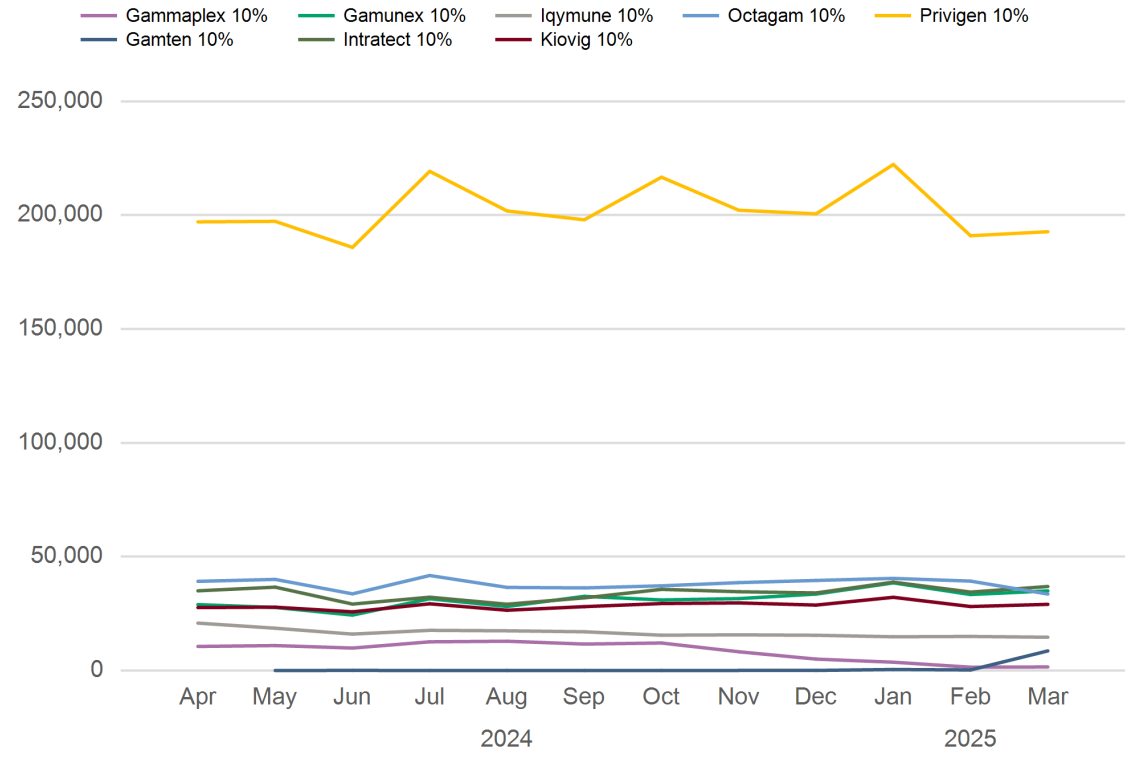

Figure 3.4.1 Yearly recorded volume of 10% IV immunoglobulin products 2017/18 - 2024/25

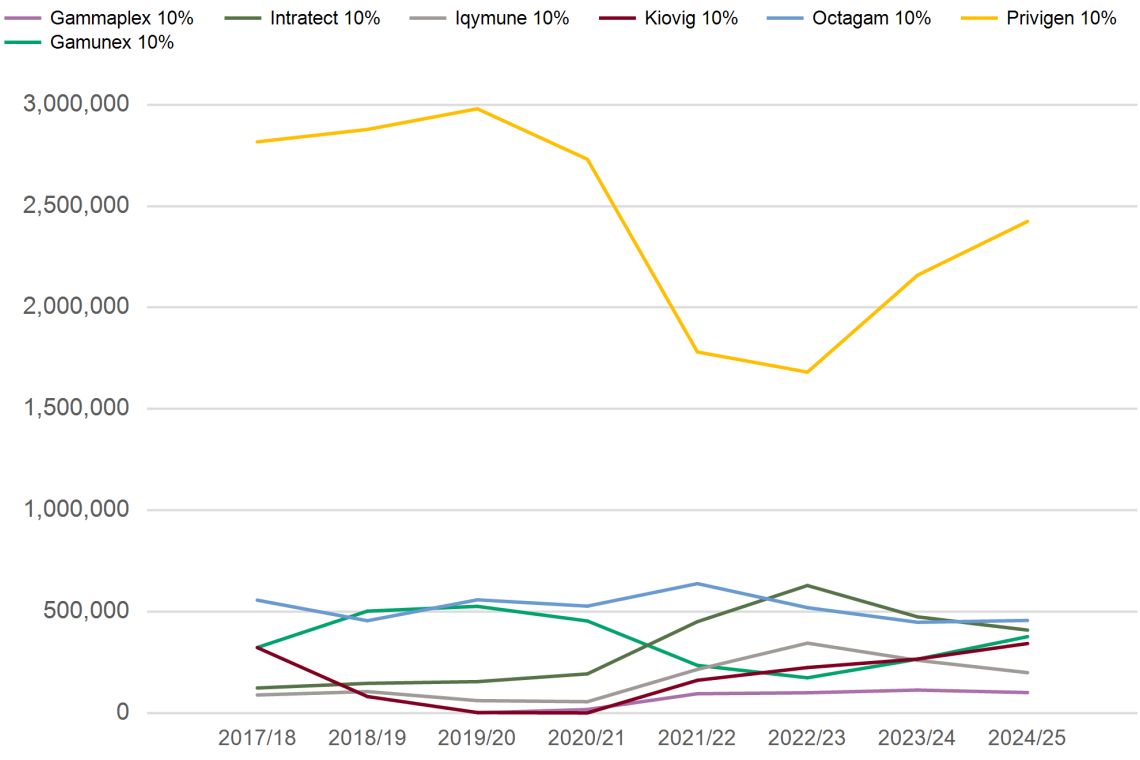

Figure 3.3.2 Monthly recorded volume of 5% IV immunoglobulin products 2024/25

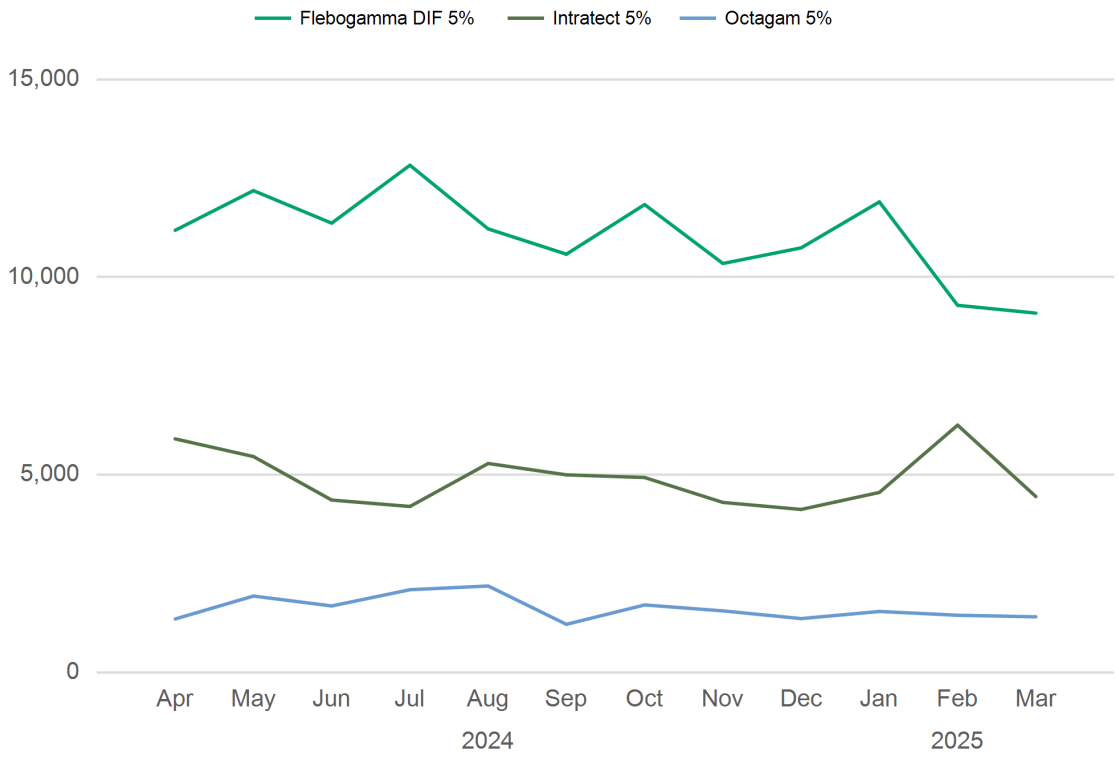

Figure 3.4.2 Yearly recorded volume of 5% IV immunoglobulin products 2017/18 - 2024/25

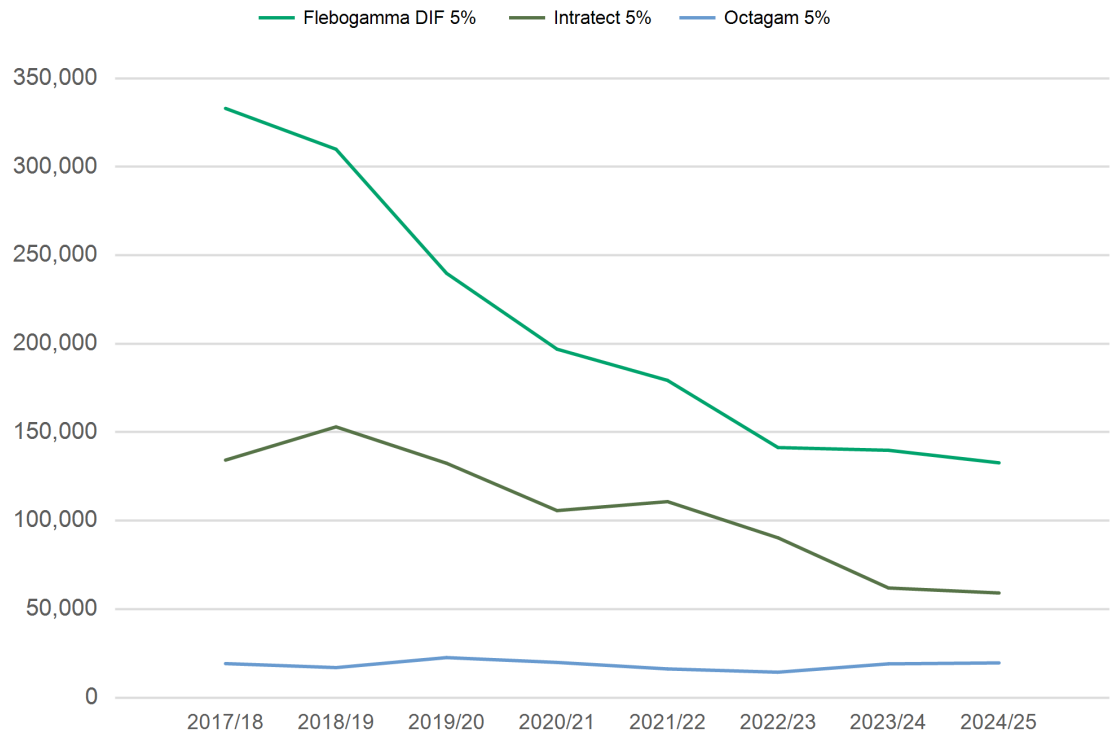

Figure 3.5 Monthly recorded volume of subcutaneous immunoglobulin products 2024/25

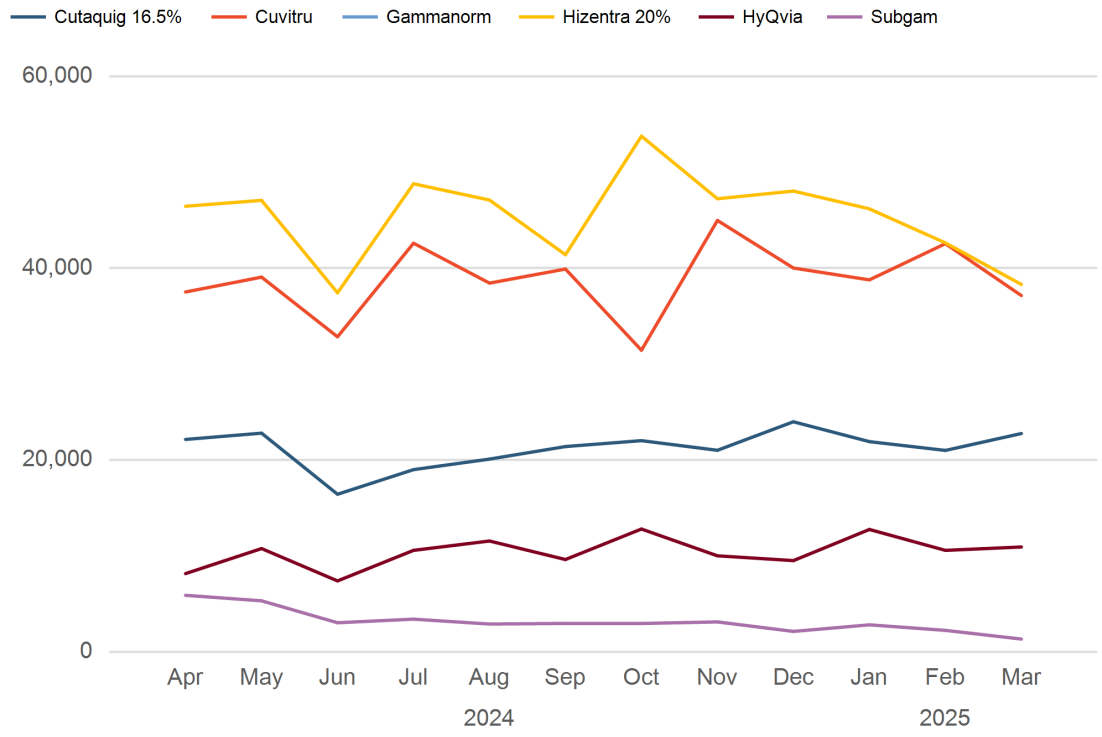

Figure 3.6 Yearly recorded volume of subcutaneous immunoglobulin products 2017/18 - 2024/25

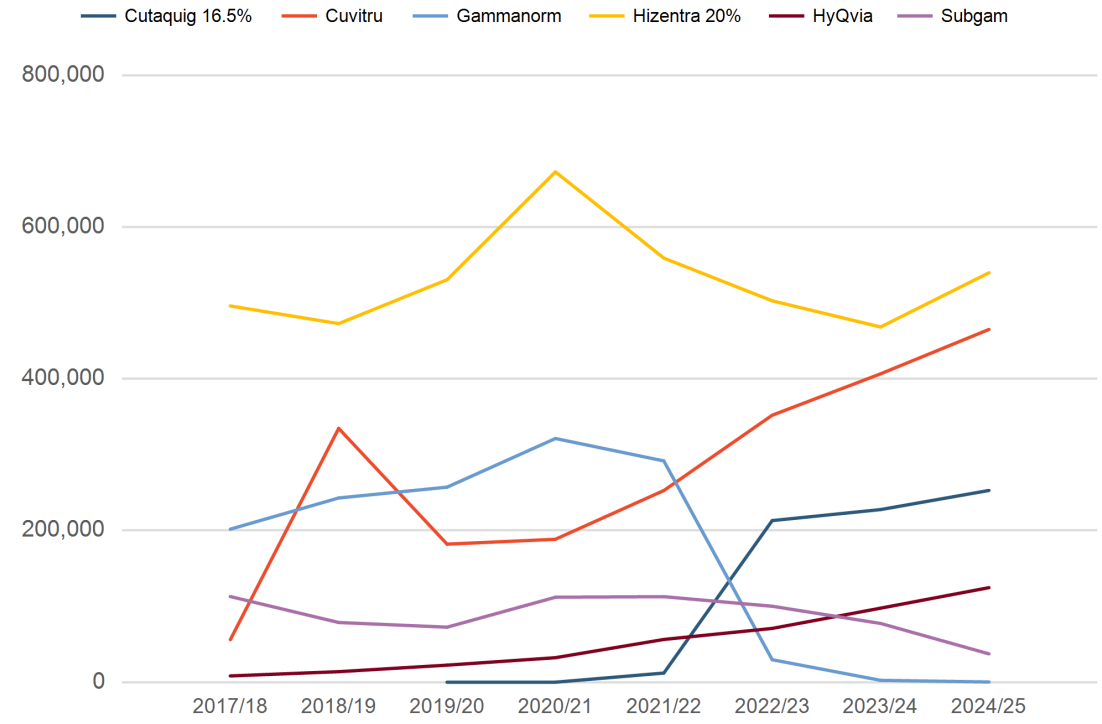

Figure 3.7 Monthly recorded volume of immunoglobulin by supplier 2024/25

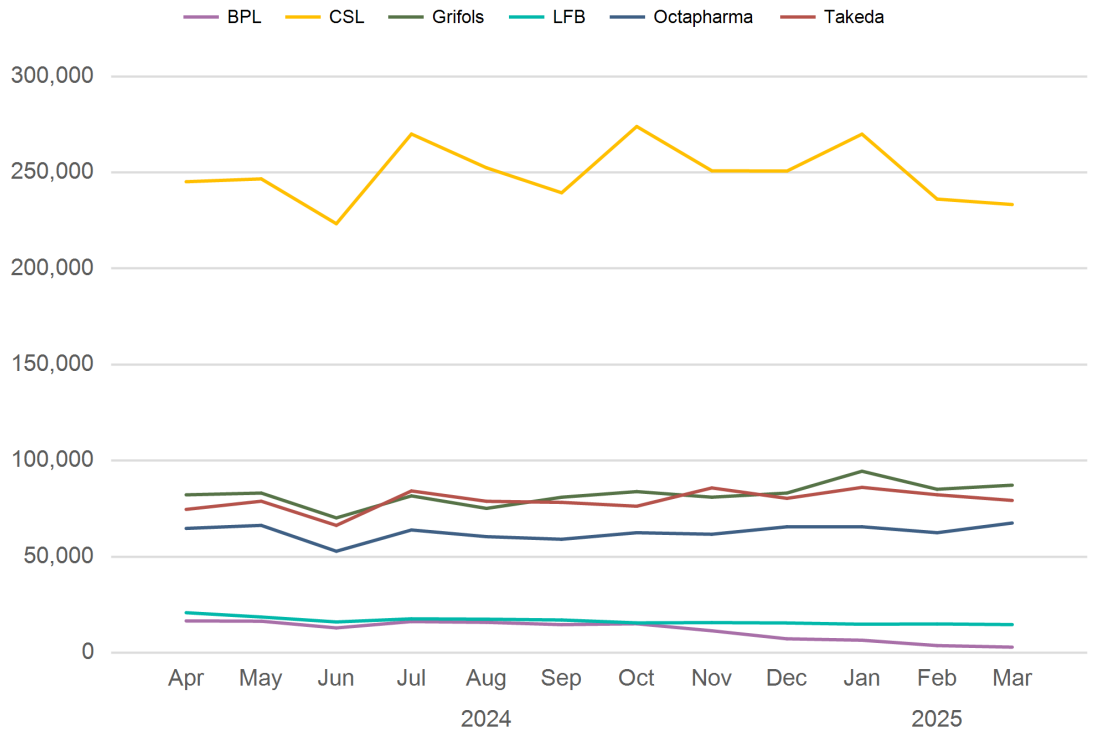

Figure 3.8 Yearly recorded volume of immunoglobulin by supplier 2017/18 - 2024/25

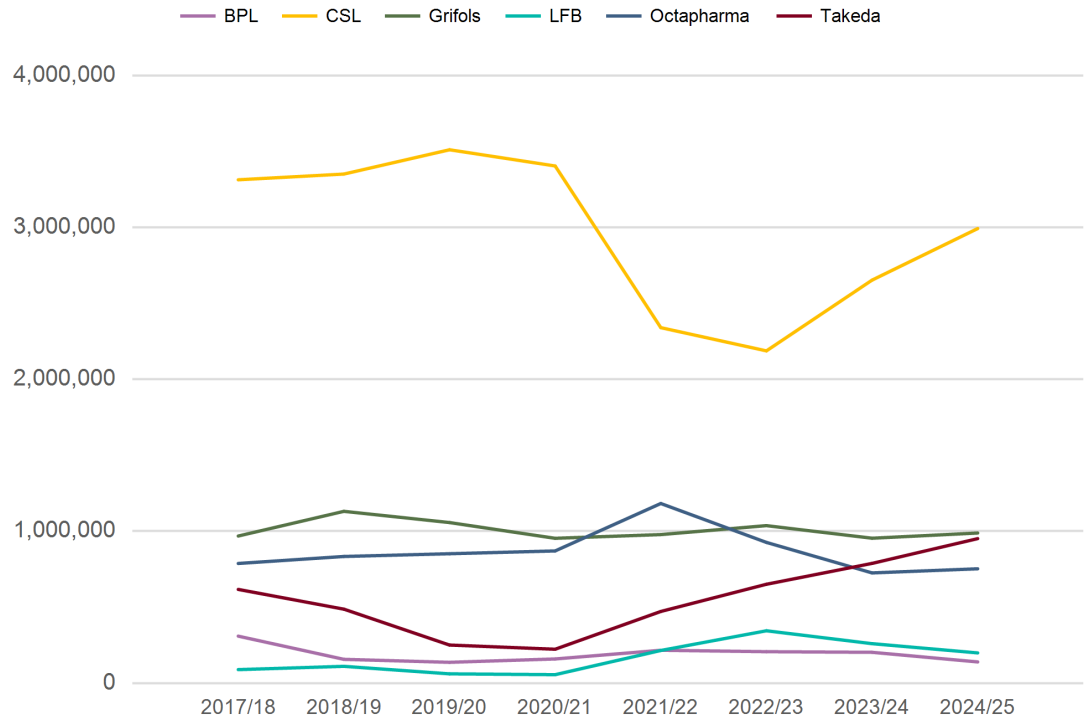

Table 4.1 ITP treatments by dose 2010/11 - 2024/25

Financial Year	g/kg	Percentage
2024/25	1g/kg and under	85%
	2g/kg and over	15%
2023/24	1g/kg and under	86%
	2g/kg and over	14%
2022/23	1g/kg and under	85%
	2g/kg and over	15%
2021/22	1g/kg and under	86%
	2g/kg and over	14%
2020/21	1g/kg and under	79%
	2g/kg and over	21%
2019/20	1g/kg and under	81%
	2g/kg and over	19%
2018/19	1g/kg and under	77%
	2g/kg and over	23%
2017/18	1g/kg and under	65%
	2g/kg and over	35%
2016/17	1g/kg and under	53%
	2g/kg and over	47%
2015/16	1g/kg and under	45%
	2g/kg and over	55%
2014/15	1g/kg and under	41%
	2g/kg and over	59%
2013/14	1g/kg and under	40%
	2g/kg and over	60%
2012/13	1g/kg and under	36%
	2g/kg and over	64%
2011/12	1g/kg and under	31%
	2g/kg and over	69%
2010/11	1g/kg and under	31%
	2g/kg and over	69%