

Recommendations for Ethical Allocation of Rho(D) Immune Globulin

APRIL 30, 2024

Background

There is a national shortage of Rho(D) immune globulin that will likely last through 2024 due to ongoing manufacturing challenges.ⁱ This shortage has affected the ability of obstetric providers in Minnesota to provide the treatment consistently and reliably to all patients. Updates on this shortage are maintained by the U.S. Food and Drug Administration online: [CBER-Regulated Products: Resolved Shortages | FDA](#).

This document provides a framework for the ethical allocation of this treatment; it is intended to guide care delivery and organizational response during this period of shortage. It also aims to provide a basis for consistent response to this situation among institutions and systems across the State of Minnesota, to promote transparency, fairness, and equity, to provide the best care possible to all patients throughout the state of Minnesota. It is based on common ethical values that have been affirmed in Minnesota through a public engagement process regarding crisis response,ⁱⁱ medical ethics literature,^{iii,iv} clinical research,^v and guidance from state^{vi}, national^{vii,viii,ix} and international^x groups. It incorporates the input of a statewide expert panel of physicians, midwives, pharmacists, blood center leadership, ethicists, and Minnesota Department of Health (MDH) staff, convened by the Metro Health & Medical Preparedness Coalition at the request of health professionals involved in managing the shortage.

This document is not legal advice, it does not carry the force or effect of law, and it should not be construed as a statement of legal or regulatory requirements and protections. Health care facilities or systems implementing strategies to manage drug shortages and other crisis situations are strongly encouraged to consult with their legal counsel, and coordinate their efforts with health system leadership, Health Care Coalition (HCC) partners, and MDH.

Ethical criteria for the allocation of Rho(D) immune globulin during the shortage

The following recommendations apply to the context of the shortage of Rho(D) immune globulin. They do not necessarily capture best practices in conventional conditions – that is, in the absence of this resource shortage.

Responsibly steward supplies of Rho(D) immune globulin:

- **Substitute:**
 - In the context of shortage of product supplied by one manufacturer, use alternative product brands if possible. Note that this may not be possible, given that alternatives may also be in short supply given protective allocations.^{xi}

- For non-obstetric uses of this treatment, use evidence-based alternatives if possible. Reserve supply for obstetric uses.
- **Conserve:**
 - If possible, conduct screening to detect Rh incompatibility rather than prophylactically treating all Rh-negative pregnant people. Screening includes:
 - Paternal ABO/Rh testing, if there is reasonable confidence concerning the identity of the biological father, and
 - Cell-free DNA testing to identify Rh status, which must be ordered in combination with aneuploidy screening. Screening availability may be limited by insurance coverage or other barriers. In the future, standalone fetal RhD screening may be available if the pregnant patient does not desire aneuploidy testing.
 - Evidence-based guidance recommends forgoing treatment for patients “prior to 12 weeks gestation for patients undergoing spontaneous, medication, or uterine aspiration abortion” except in cases of “ectopic pregnancy, sharp curettage, or other invasive procedures”.^{xii,xiii} Similarly, forgo treatment in cases of trauma prior to 12 weeks gestation, unless there is evidence of uterine or placental injury involving possible bleeding.
 - Splitting 300 mcg doses is not recommended as a strategy to conserve supply, because:
 - Forgoing treatment for patients prior to 12 weeks gestation as outlined above will better conserve supply in that context, and
 - Splitting doses to reduce dosage at other points in pregnancy may result in wasted doses.
 - Treatment packaged in reduced doses (e.g., 50 mcg) should be used as clinically indicated.

Maximize benefit of this scarce resource while minimizing harms or inequities:

- Clinical risks and benefits of treatment should guide treatment decisions. If there is insufficient supply to treat all patients who would normally receive treatment, even after implementing the substitution and conservation strategies outlined above, prioritize patients seeking postpartum doses of Rho(D) immune globulin over those seeking routine dosing at 28 weeks, to maximize benefit from scarce treatment supplies.
- Patients undergoing immediate postpartum sterilizing procedures to prevent future pregnancies (for example, tubal ligation, hysterectomy) should be engaged in a process of appropriate counselling but should generally not be administered postpartum Rho(D) immune globulin doses in a context of scarcity unless clinical risks or the potential benefits of treatment indicate that treatment should be provided.

RHO(D) IMMUNE GLOBULIN SHORTAGE RECOMMENDATIONS

- Decisions about treatment allocation priorities should not consider or be based upon nonclinical considerations such as:
 - Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, disability status, or socioeconomic status,
 - Ability to pay (Note that while ability to pay may affect access to cell-free DNA testing to identify Rh status, this procedure is encouraged as a conservation measure, if possible, not required for access to treatment. Ability to pay should not pose a barrier to access to treatment),
 - Whether the patient regularly receives care from a particular health facility or system,
 - First come, first served,
 - Judgments that some people have greater “quality of life” than others,
 - Judgments that some people have greater “social value” than others.
- Health systems/facilities should partner to consider how best to equitably support patients who should be prioritized for allocation but cannot access treatment. While all health systems/facilities/providers in the state are affected by the shortage of these treatment resources, the severity of shortages may vary across facilities/providers. If any provider in the state is caring for a patient who qualifies for prioritized allocation of Rho(D) immune globulin, but lacks supply to provide treatment, that provider may reach out to the Regional Healthcare Preparedness Coordinator (RHPC) for the Metro Region at 612-873-9911 to help identify available supply for that patient. To promote equity, the RHPC for the Metro Region will help connect providers statewide to available doses of treatment.
- If possible, it will be more efficient, and so will better meet the needs of patients, if the following processes are implemented to facilitate sharing of doses:
 - Systems/facilities partner should partner directly with free-standing birth centers, if possible, to meet their needs for doses of Rho(D) immune globulin. If it is not possible for a free-standing birth center to create such a partnership with a health care facility/system, the birth center should reach out to the RHPC for the Metro Region to seek assistance in securing needed doses. Contact information for the RHPC is provided above, and a SharePoint spreadsheet has been created and shared with providers to promote situational awareness/tracking of supply and doses shared.
 - Home birth providers should coordinate with the Minnesota Council of Certified Professional Midwives (MCCPM) regarding their need for treatment doses. A representative of the MCCPM will reach out to the Regional Healthcare Resource Center (RHRC) (contact information 612-873-9911) to seek assistance in securing needed doses. The home birth provider will then connect with the supplying facility/system to access the dose(s).

RHO(D) IMMUNE GLOBULIN SHORTAGE RECOMMENDATIONS

- Systems/facilities should report their ability to share doses on a regular basis with the RHPC from the Metro Region, so RHPCs are aware of available supplies and can avoid having to call multiple systems to locate treatment for each patient that needs it.
- If possible, it would be more equitable to transfer Rho(D) immune globulin doses between licensed systems/facilities or between licensed providers, since this will avoid unduly disadvantaging the patient by requiring travel, additional expense, or other burdens to access the treatment.

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4/30/2024

To obtain this information in a different format, call: 651-201-5700.

ⁱ [CBER-Regulated Products: Current Shortages | FDA](#)

ⁱⁱ Minnesota Department of Health (MDH). Minnesota Crisis Standards of Care Framework: Ethical Guidance. Updated: 01/10/2020. Available at <https://www.health.state.mn.us/communities/ep/surge/crisis/framework.pdf>.

ⁱⁱⁱ Michael Manolakis, Ethical integrity in managing drug shortages, *American Journal of Health-System Pharmacy*, Volume 69, Issue 1, 1 January 2012, Page 17, <https://doi.org/10.2146/ajhp110640>

^{iv} Philip M. Rosoff. Unpredictable Drug Shortages: An Ethical Framework for Short-Term Rationing in Hospitals. *The American Journal of Bioethics* 12:1, 2012: 1-9. Available at <https://www.tandfonline.com/doi/full/10.1080/15265161.2011.634483?scroll=top&needAccess=true&role=tab>.

^v Horvath S, Huang Z, Koelper NC, et al. Induced Abortion and the Risk of Rh Sensitization. *JAMA*. 2023;330(12):1167–1174. doi:10.1001/jama.2023.16953

^{vi} Minnesota Department of Health. Patient Care Strategies for Scarce Resource Situations: Medication Administration. August 2021. <https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf>

^{vii} Sarah Horvath, Vinita Goyal, Sarah Traxler, Sarah Prager, Society of Family Planning committee consensus on Rh testing in early pregnancy, *Contraception*, Volume 114, 2022, Pages 1-5, ISSN 0010-7824, <https://www.sciencedirect.com/science/article/pii/S0010782422001974>

^{viii} American College of Obstetricians and Gynecologists (ACOG). Rho(D) Immune Globulin Shortages: Practice Advisory. March 2024 <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2024/03/rhod-immune-globulin-shortages>

^{ix} American College of Obstetricians and Gynecologists (ACOG). Rho(D) Immune Globulin Shortages: Practice Advisory. April 24, 2024. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2024/03/rhod-immune-globulin-shortages?utm_source=higher-logic&utm_medium=email&utm_content=Apr-26&utm_campaign=acog2024-rounds

^x World Health Organization. Abortion Care Guideline: Chapter 3. Recommendations and best practice statements across the continuum of abortion care: Clinical services Recommendation 8: Rh isoimmunization for abortion at gestational ages < 12 weeks (3.3.3). 2022. <https://srhr.org/abortioncare/chapter-3/pre-abortion-3-3/clinical-services-recommendation-8-rh-isoimmunization-for-abortion-at-gestational-ages-12-weeks-3-3-3/>

^{xi} Association for Advancement of Blood and Biotherapies. Regulatory update: FDA announces shortages of Rho(D) immune globulin. February 14, 2024. [https://www.aabb.org/news-resources/news/article/2024/02/14/regulatory-update--fda-announces-shortages-of-rho\(d\)-immune-globulin](https://www.aabb.org/news-resources/news/article/2024/02/14/regulatory-update--fda-announces-shortages-of-rho(d)-immune-globulin)

^{xii} Sarah Horvath, Vinita Goyal, Sarah Traxler, Sarah Prager, Society of Family Planning committee consensus on Rh testing in early pregnancy, *Contraception*, Volume 114, 2022, Pages 1-5, ISSN 0010-7824, <https://www.sciencedirect.com/science/article/pii/S0010782422001974>

^{xiii} Horvath S, Huang Z, Koelper NC, et al. Induced Abortion and the Risk of Rh Sensitization. *JAMA*. 2023;330(12):1167–1174. doi:10.1001/jama.2023.16953