

**Clinical Policy: Efgartigimod Alfa-fcab (Vyvgart)**

Reference Number: CP.PHAR.555

Effective Date: 12.17.21

Last Review Date: 02.23

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Efgartigimod alfa-fcab (Vyvgart<sup>®</sup>) is a neonatal Fc receptor (FcRn) antagonist.

**FDA Approved Indication(s)**

Vyvgart is indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Vyvgart is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Generalized Myasthenia Gravis (must meet all):**

1. Diagnosis of gMG;
2. Prescribed by or in consultation with a neurologist;
3. Age  $\geq$  18 years;
4. Myasthenia Gravis-Activities of Daily Living (MG-ADL) score  $\geq$  5 at baseline;
5. Greater than 50% of the baseline MG-ADL score is due to non-ocular symptoms;
6. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV;
7. Member has positive serologic test for anti-AChR antibodies;
8. Failure of a cholinesterase inhibitor (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;
9. Failure of a corticosteroid (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;
10. Failure of at least one immunosuppressive therapy (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;
11. Vyvgart is not prescribed concurrently with Soliris<sup>®</sup> or Ultomiris<sup>®</sup>;
12. Documentation of member's current weight (in kg);
13. Dose does not exceed 10 mg/kg (1,200 mg per infusion for members weighing 120 kg or more) once weekly for the first 4 weeks of every 8-week cycle.

**Approval duration: 6 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Generalized Myasthenia Gravis (must meet all):**

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy as evidenced by a 2-point reduction in MG-ADL total score;
3. Vyvgart is not prescribed concurrently with Soliris or Ultomiris;
4. Documentation of member's current weight (in kg);
5. If request is for a dose increase, new dose does not exceed 10 mg/kg (1,200 mg per infusion for members weighing 120 kg or more) once weekly for the first 4 weeks of every 8-week cycle.

**Approval duration: 6 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

AChR: acetylcholine receptor

FcRn: neonatal Fc receptor

FDA: Food and Drug Administration

gMG: generalized myasthenia gravis

IgG: immunoglobulin G

MG-ADL: Myasthenia Gravis-Activities of Daily Living

MGFA: Myasthenia Gravis Foundation of America

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
<b>Corticosteroids</b>		
betamethasone	Oral: 0.6 to 7.2 mg PO per day	7.2 mg/day
dexamethasone	Oral: 0.75 to 9 mg/day PO	9 mg/day
methylprednisolone	Oral: 12 to 20 mg PO per day; increase as needed by 4 mg every 2-3 days until there is marked clinical improvement	40 mg/day
prednisone	Oral: 15 mg/day to 20 mg/day; increase by 5 mg every 2-3 days as needed	60 mg/day
<b>Cholinesterase Inhibitors</b>		
pyridostigmine (Mestinon <sup>®</sup> )	Oral immediate-release: 600 mg daily in divided doses (range, 60-1,500 mg daily in divided doses) Oral sustained release: 180-540 mg QD or BID	Immediate-release: 1,500 mg/day Sustained-release: 1,080 mg/day
neostigmine (Bloxivert <sup>®</sup> )	Oral: 15 mg TID. The daily dosage should be gradually increased at intervals of 1 or more	Oral: 375 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	days. The usual maintenance dosage is 15-375 mg/day (average 150 mg) IM or SC: 0.5 mg based on response to therapy	
<b>Immunosuppressants</b>		
azathioprine (Imuran <sup>®</sup> )*	Oral: 50 mg QD for 1 week, then increase gradually to 2 to 3 mg/kg/day	3 mg/kg/day
mycophenolate mofetil (Cellcept <sup>®</sup> )*	Oral: Dosage not established. 1 gram BID has been used with adjunctive corticosteroids or other non-steroidal immunosuppressive medications	2 g/day
cyclosporine (Sandimmune <sup>®</sup> )*	Oral: initial dose of cyclosporine (non-modified), 5 mg/kg/day in 2 divided doses	5 mg/kg/day
Rituxan <sup>®</sup> (rituximab), Riabni <sup>™</sup> (rituximab-arrx), Ruxience <sup>™</sup> (rituximab-pvvr), Truxima <sup>®</sup> (rituximab-abbs)*†	IV: 375 mg/m <sup>2</sup> once a week for 4 weeks; an additional 375 mg/m <sup>2</sup> dose may be given every 1 to 3 months afterwards	375 mg/m <sup>2</sup>

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

\*Off-label; †Prior authorization is required for rituximab products

#### Appendix C: Contraindications/Boxed Warnings

None reported

#### Appendix D: General Information

- The MG-ADL scale is an 8-item patient-reported scale that measures functional status in 8 domains related to MG – talking, chewing, swallowing, breathing, impairment of ability to brush teeth or comb hair, impairment of ability to arise from a chair, double vision, and eyelid droop. Each domain is given a score of 0-3, with 0 being normal and 3 being most severe impairment. A 2-point decrease in the MG-ADL score is considered a clinically meaningful response.
- In the Phase 3 ADAPT trial, all study patients received an initial 4-week treatment cycle of Vyvgart, with subsequent cycles administered according to individual clinical response when MG-ADL score was  $\geq 5$  (i.e., symptoms are at least the minimum threshold required for necessitating treatment) and, if the patient was an MG-ADL responder to the 4-week treatment cycle, when they no longer had a clinically meaningful decrease (MG-ADL clinically meaningful improvement defined as having  $\geq 2$ -point improvement in total MG-ADL score) compared with baseline. Subsequent cycles could commence no sooner than 8 weeks from initiation of the previous cycle.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
gMG	10 mg/kg IV once weekly for the first 4 weeks of every 8-week cycle	10 mg/kg/week (1,200 mg per infusion for members weighing ≥ 120 kg)

**VI. Product Availability**

Single-dose vial: 400 mg/20 mL injection solution

**VII. References**

1. Vyvgart Prescribing Information. Boston, MA: argenx US, Inc.; April 2022. Available at: <https://argenx.com/product/vyvgart-prescribing-information.pdf>. Accessed November 22, 2022.
2. Howard JF, Bril V, Vu T, et al. Safety, efficacy, and tolerability of efgartigimod in patients with generalized myasthenia gravis (ADAPT): a multicenter, randomized, placebo-controlled, phase 3 trial. *Lancet Neurology* July 2021;20(7):526-36.
3. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. *Neurology* 2016;87:419-425.
4. Narayanaswami P, Sanders DB, Wolfe G, et al. International consensus guidance for management of myasthenia gravis 2020 update. *Neurology* 2021;96:114-22.
5. Muppidi S, Silvestri N, Tan R, et al. The evolution of Myasthenia Gravis-Activities of Daily Living (MG-ADL) scale utilization to measure myasthenia gravis symptoms and treatment response (1817). *Neurology* Apr 2021;96(15 Suppl):1817.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9332	Injection, efgartigimod alfa-fcab, 2 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	08.17.21	11.21
Drug is now FDA approved – criteria updated per FDA labeling: revised requirement for a prior trial of two non-steroidal immunosuppressant therapies to a trial of at least one; added requirement for documentation of member’s current weight for dose calculation purposes; references reviewed and updated.	01.04.22	02.22
Added HCPCS code [J9332].	06.30.22	
Updated requirement for no concurrent use to include Ultomiris.	08.09.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added to continuation of therapy requirement for no concurrent use with Soliris or Ultomiris. Template changes applied to other diagnoses/indications and continued therapy section.	08.23.22	11.22
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.22.22	02.23

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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