DR.023.A Vyvgart (Efgartigimod alfa-fcab)

Original Implementation Date : 11/03/2025
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Last Reviewed Date: 09/18/2025

***** NOTIFICATION OF PENDING POLICY IMPLEMENTATION *****

Please note that this Policy Bulletin will be implemented on 11/03/2025.

This document provides a 30-day notification of its pending implementation and is not currently implemented.

PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans/Health Partners Plans lines of business unless noted below.

POLICY STATEMENT

The plan considers **Vyvgart (efgartigimod alfa-fcab) and Vyvgart Hytrulo® (efgartigimod alfa and hyaluronidase-qvfc)** medically necessary for its FDA approved indications when the prior authorization criteria listed in this policy are met.

FDA APPROVED INDICATIONS

Vyvart is indicated for the treatment of:

- Adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive.

Vyvgart Hytrulo® is indicated for the treatment of:

- Adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive.

- Adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP).

OFF-LABEL USE

Authorization for off-labeled use of medication will be evaluated on an individual basis. Review of an off-labeled request by the Medical Staff will be predicated on the appropriateness of treatment and full consideration of medical necessity. For off-label use Medical Directors will review scientific literature and local practice patterns.

PRIOR AUTHORIZATION CRITERIA

Initial Criteria:

gMG:

1. Medication is prescribed by a neurologist in accordance with FDA package labeling concerning the dose and interval of use for the indication **AND**

2. Member is 18 years or older and has confirmed anti-acetylcholine receptor antibody positive generalized myasthenia gravis **AND**

3. Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV **AND**

4. MG-Activities of Daily Living (MG-ADL) total score of ≥ 5 **AND**

5. Member has **one** of the following:

    - Documented trial and failure of 2 immunosuppressive medications over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, tacrolimus); *or*
    - Failure or intolerable to at least one immunosuppressive therapy and intravenous immunoglobulin (IVIG) over the course of at least 12 months; *or*
    - Documented clinical reason to avoid therapy with immunosuppressive agents and IVIG

6. The requested medication will not be used in combination with another neonatal Fc receptor blocker (e.g., Rystiggo) or complement inhibitor (e.g., Soliris, Ultomiris®, Zilbrysq®).

    IF ALL CRITERIA MET, APPROVE FOR 6 MONTHS

CIDP (Vyvgart Hytrulo® only):

1. Member is at least 18 years of age **AND**

2. Disease is progressive or relapsing/remitting for 2 months or longer **AND**

3. Diagnosis confirmed by electrodiagnostic testing (consistent with EFNS/PNS guidelines) **AND**

4. Member has decreased or absent deep tendon reflexes in upper or lower limbs **AND**

5. Meets **one** of the following:

    a. Had inadequate response or intolerable adverse events to immunoglobulins, corticosteroids, or plasma exchange

    b. Has a documented clinical reason to avoid therapy with immunoglobulin, corticosteroids, or plasma exchange

IF ALL CRITERIA ARE MET, APPROVE FOR 6 MONTHS

RENEWAL CRITERIA

gMG:

- Documentation of beneficial response while using Vyvgart for gMG **AND**

- Has had an improvement (i.e. reduction) of at least 1-point from baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-AGL) total score **AND**

- Patient requires continuous treatment, after an initial beneficial response, due to new or worsening disease activity (Note: a minimum of 50 days must have elapsed from the start of previous treatment cycle)

CIDP (Vyvgart Hytrulo only):

- Demonstrated a clinical response to therapy based on objective clinical measuring tool (e.g. INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Randkin, etc.)

DOSAGE AND ADMINISTRATION

VYVGART (**Intravenous Infusion)** is available as 400 mg in 20 mL (20 mg/mL) single-dose vial for intravenous infusion only.

(gMG): recommended dose

- Evaluate the need to administer age-appropriate vaccines according to immunization guidelines before initiation of a new treatment cycle with Vyvgart.
- Administer 10 mg/kg (maximum dose: 1,200 mg) as intravenous infusion once weekly for 4 weeks. In patients weighing ≥ 120 kg, the recommended dose is 1,200 mg per infusion.
- Subsequent treatment cycles of 10 mg/kg (maximum dose: 1,200 mg) once weekly for 4 weeks may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.
- Must dilute in 0.9% Sodium Chloride Injection, USP prior to administration.
- Infusion over one hour via a 0.2 micron in-line filter.

- **VYVGART HYTRULO® (Subcutaneous Injection)** is available as 1,000 mg efgartigimod alfa/10,000 units hyaluronidase per 5 mL single-dose prefilled syringe (200 mg/ 2,000 units per mL) and 1,008 mg efgartigimod alfa/11,200 units hyaluronidase per 5.6 mL single-dose vial (180 mg/2,000 units per mL). For subcutaneous injection only. Do not dilute. Administer vials.

RISK FACTORS/SIDE EFFECTS

VYVGART and VYVGART HYTRULO

- The most common adverse reactions: respiratory tract infections, headache, and urinary tract infection, and Injection site reactions.
- **Hypersensitivity Reactions**:. Anaphylaxis, hypotension leading to syncope, angioedema, dyspnea, and rash; address appropriately and provide medical care.
- **Infusion-related reactions:** Hypertension, chills, shivering, and thoracic, abdominal, and back pain. If severe infusion-related reactions occur, discontinue infusion and initiate appropriate therapy; consider risks and benefits of readministering. If mild to moderate reactions, may rechallenge with close monitoring, slower infusions, and pre-medications.
- **Infections:** Delayed administration of Vyvgart to patients with an active infection. Monitor for signs and symptoms of infection in patients. If serious infections occur, administer appropriate treatment and withhold treatment until the infection is resolved.

MONITORING

Signs and symptoms of hypersensitivity reaction (during infusion and for 1 hour after infusion completion), infusion reaction, and infection.

Closely monitor for reduced effectiveness of medications that bind to the human neonatal Fc receptor. When concomitant long-term use of such medications is essential for patient care, consider discontinuing VYVGART and using alternative therapies.

CONTRAINDICATIONS

VYVGART and VYVGART HYTRULO

In patients with serious hypersensitivity to efgartigimod alfa products or to any excipients of Vyvgart and Vyvgart Hytrulo®.

Black Box Warning

N/A

CLINICAL EVIDENCE

gMG:

Efgartigimod was found to be effective in the 26 week multicenter ADAPT trial that included 167 patients with generalized MG from North America, Europe, and Japan. Most patients had AChR antibodies positive (77 percent), Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV, MG-Activities of Daily Living (MG-ADL) total score of ≥ 5, on stable dose of MG therapy prior to screening(included acetylcholinesterase (AChE) inhibitors, steroids, or non-steroidal immunosuppressive therapies (NSISTs), either in combination or alone), IgG levels of at least 6 g/L. Symptomatic improvement of at least two points in the MG Activities of Daily Living score was more common in patients assigned to weekly infusions of efgartigimod 10 mg/kg IV for four weeks than in those assigned to placebo (68 versus 30 percent). The rate of adverse effects was similar in treatment and placebo groups; headache, nasopharyngitis, and upper respiratory

infection were reported most frequently. On the basis of these data, efgartigimod was approved by the FDA and in Japan for use in AchR antibody-positive patients with generalized MG.

In a subsequent single-center retrospective review of 17 patients who were treated with efgartigimod, a >50 percent improvement in nonocular symptoms was reported by 16 patients (94 percent) at three-month follow-up. Mean improvements in baseline MG-ADL score were 5.5 and 7.1 points at three and six months, respectively. Most patients were taking glucocorticoids, but only 41 percent had attempted a steroid-sparing agent. Efgartigimod was selected for most patients due to a poor response or contraindication to other therapies.

In another series of 16 patients with MG that was refractory to maintenance intravenous immune globulin, plasma exchange, or at least two immunotherapies, 50 percent (eight patients) reported a favorable response in the MG-ADL score by the end of the first treatment cycle. Most patients were also able to reduce the dosing of glucocorticoid and/or other immunotherapies.

CIDP:

In a multistage clinical trial of 322 patients with CIDP receiving weekly infusions of EFG-aH, the initial clinical response rate was 66 percent by 12 weeks. The response rate was higher among patients who were previously treated with glucocorticoids or no immunotherapy (72 and 78 percent, respectively) than those previously treated with IVIG (59 percent). In a subsequent placebo-controlled stage offered to responders, patients who received EFG-aH had a lower rate of clinical deterioration than those who received placebo (28 versus 54 percent; hazard ratio 0.39, 95% CI 0.25-0.61) at 48-week follow-up [.

Based on these trial results, EFG-aH was approved for use by the United States Food and Drug Administration (FDA) for patients with CIDP in 2024

Further studies are warranted to help assess the longer-term benefit, to identify optimal patients for this therapy, and to determine how best to transition from immune globulin to EFG-aH.

BACKGROUND

gMG:

Myasthenia gravis (MG) is an autoimmune neuromuscular disorder characterized by fluctuating motor weakness involving ocular, bulbar, limb, and/or respiratory muscles. The weakness is due to an antibody-mediated, immunologic attack directed at proteins in the postsynaptic membrane of the neuromuscular junction (acetylcholine receptors or receptor-associated proteins). MG is the most common disorder of neuromuscular transmission.

MG is a relatively uncommon disorder with an annual incidence of approximately 7 to 30 new cases per million .The prevalence is approximately 70 to 370 per million .The prevalence of the disease has been increasing since the mid-20th century, likely due to better recognition of the condition, aging of the population, and the longer life span of affected patients.

MG occurs at any age, but there tends to be a bimodal distribution to the age and sex predominance of onset, with an early peak in the second and third decades (female predominance) and a late peak in the sixth to eighth decade (male predominance).

The clinical manifestations of MG can vary from mild and focal weakness in some patients to severe tetraparesis with respiratory failure in others. Symptom severity may also vary substantially in an individual patient throughout the day and over the course of the condition. Classification systems stratify patients by symptoms or diagnostic findings to specify the severity of impairment and to aid with management.

There are two clinical forms of MG: ocular and generalized.

- Ocular MG – Weakness is limited to the eyelids and extraocular muscles.

- Generalized MG – Weakness involves a variable combination of ocular, bulbar, limb, and respiratory muscles.

The pathophysiology of ocular MG is the same as generalized MG, but the sensitivities of diagnostic tests and treatments can vary between these clinical forms. Many patients with ocular MG eventually progress to generalized MG. Approximately 80 percent of patients (45 to 60 percent in most studies) "generalize" by two to three years .There are no factors that predict which patients who present with ocular disease will develop generalized MG. Autoantibody and electrodiagnostic testing to assess subclinical generalized involvement do not reliably predict which patients will develop generalized MG.

MG may be categorized by symptom severity to guide treatment decisions, determine eligibility for clinical trials, and help with prognostication. A widely used classification system from a task force of the Myasthenia Gravis Foundation of America (MGFA) stratifies patients by the extent and severity of muscle weakness :

- Class I – Isolated ocular muscle weakness

- Class II – Mild generalized weakness involving nonocular muscles

- Class III – Moderate generalized weakness involving nonocular muscles

- Class IV – Severe generalized weakness involving nonocular muscles

•Class V – Intubation due to respiratory muscle weakness

The MG Activities of Daily Living score is used to quantify the severity of patient-reported symptoms Scoring is rated from zero to three in eight domains including talking, chewing, swallowing, breathing, teeth brushing/hair combing, ability to stand from a chair, presence of double vision, and eyelid drooping.

Although data are limited, MG may be associated with increased mortality. In a population-based study from Denmark, overall mortality was significantly increased for subjects with acetylcholine receptor-antibody-seropositive MG compared with matched controls from the general population (mortality rate ratio 1.41, 95% CI 1.24-1.60) . However, other contemporary studies have not found an increased mortality rate, perhaps due to better disease management with the increasing availability of effective immunotherapies .

CIDP

Chronic inflammatory demyelinating polyneuropathy (CIDP) is an acquired, immune-mediated neuropathy affecting peripheral nerves and nerve roots, typically characterized by a relapsing-remitting or progressive course of symmetric weakness of proximal and distal muscles. CIDP is identified by electrodiagnostic and/or pathologic features of demyelination and responsiveness to immunomodulatory treatments.

CIDP prevalence ranges from 0.7 to 10.3 cases per 100,000 people with predominance in males, and primarily affects adults, the incidence rises with advancing age.

The disease usually presents with gradually progressive symptoms over the course of several months or longer.

Some patients develop more rapidly progressive symptoms-acute inflammatory demyelinating polyneuropathy (AIDP) which have been termed "acute-onset CIDP"

Several variants of CIDP are distinguished by their clinical presentation and/or pathogenic mechanism. The forms of CIDP recognized as variants by the European Academy of Neurology (EAN) and the Peripheral Nerve Society (PNS) criteria include :

Multifocal CIDP, Focal CIDP, Motor CIDP, Sensory CIDP, Distal CIDP.

The diagnosis of CIDP should be considered in patients presenting with a progressive or relapsing-remitting polyneuropathy involving both motor and sensory axons along with areflexia, particularly when weakness predominates and affects proximal and distal muscles simultaneously and symmetrically. Symptom progression or relapses must be present for at least eight weeks.

The characteristic electrophysiologic features of CIDP are those of peripheral nerve demyelination and include:

Partial conduction block, Conduction velocity slowing, Prolonged distal motor latencies, Delay or disappearance of F waves, Temporal dispersion and distance-dependent reduction of compound motor action potential (CMAP) amplitude.

There are no laboratory test findings that specifically point to CIDP. The purpose of testing is to look for disorders that are either associated with or mimic CIDP.

Cerebrospinal fluid (CSF) analysis is performed for patients with suspected CIDP when the clinical and electrophysiologic findings are nondiagnostic. Albuminocytologic dissociation is a hallmark of CIDP and represents supportive evidence in the EAN/PNS diagnostic criteria

CSF protein is elevated (>45 mg/dL) and the CSF white cell count is normal (ie, the classic albuminocytologic dissociation) in over 80 percent of patients with CIDP).

CODING

Note*:* The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that *may* be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

HCPCS Code	Description
J9332	Injection, efgartigimod alfa-fcab, 2mg
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc

ICD-10 Codes	Description
G61.81	Chronic inflammatory demyelinating polyneuritis

G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

For Health Partners Plans Medicaid and Health Partners Plans Chip products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
New policy.	A	11/03/2025

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1-888-991-9023
1101 Market Street, Suite 3000
Philadelphia, PA 19107
JeffersonHealthPlans.com