Pharmacy Drug Policy Checklist

POLICY NAME	Rystiggo (rozanolixizumab)	POLICY #	3194P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of generalized myasthenia gravis with positive blood genetic test for anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibodies
- ☐ **1.2** Documentation to support a Myasthenia Gravis Foundation of America Clinical Classification of II, III, or IV at the start of therapy
- ☐ **1.3** Documentation to support a Myasthenia Gravis-Activities of Daily Living Score (MG-ADL) score greater than or equal to 3
- ☐ **1.4** Documentation to support a quantitative myasthenia gravis (QMG) score greater than or equal to 11
- ☐ **1.5** Age 18 years or older
- ☐ **1.6** Prescribed by or in consultation with a neurologist (nervous system doctor) or physician that specializes in treatment of generalized myasthenia gravis
- ☐ **1.7** Trial and failure, intolerance or contraindication to standard of care therapies (such as pyridostigmine, mycophenolate, etc)
- ☐ **1.8** For patients with anti-acetylcholine receptor (AChR) antibodies; previous trial and failure, intolerance or contraindication to at least one treatment cycle of Vyvgart
- ☐ **1.9** Review of chart notes documenting diagnosis and confirming that the patient has met all of the above requirements for treatment with Rystiggo by both a pharmacist and medical director

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** Rystiggo will not be covered in addition to Vyvgart, Soliris or Ultomiris