Pharmacy Drug Policy Checklist

POLICY NAME	Vyvgart (efgartigimod alfa)	POLICY #	3140P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **3.1** Vyvgart will not be covered in addition to Rystiggo, Soliris or Ultomiris
- ☐ **3.2** Polyneuropathy of other causes
  - Vyvgart Hytrulo is not supported in the treatment of polyneuropathy related to any other condition

Coverage Criteria for Myasthenia Gravis

- ☐ **1.1** Diagnosis of generalized myasthenia gravis with positive serological test for anti-AChR 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 ≥5
- ☐ **1.4** Prescribed by or in consultation with a neurologist or physician that specializes in treatment of generalized myasthenia gravis
- ☐ **1.5** Trial, failure, or contraindication to conventional therapies (i.e. pyridostigmine, immunosuppressant therapies)
- ☐ **1.6** Review of chart notes documenting diagnosis and confirming that the patient has met all of the above requirements for treatment with Vyvgart by both a pharmacist and medical director

Coverage Criteria for Chronic Inflammatory Demyelinating Polyneuropathy (Vyvgart Hytrulo only)

- ☐ **2.1** Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) as confirmed by progressive or relapsing motor or sensory impairment of more than one limb for more than 2 months
- ☐ **2.2** Age 18 years or older
- ☐ **2.3** Prescribed by or in consultation with a neurologist
- ☐ **2.4** Documented trial and failure, intolerance or contraindication to corticosteroids
- ☐ **2.5** Documented trial and failure, intolerance or contraindication to a formulary immune globulin product