

Pharmacy Drug Policy Checklist

POLICY NAME Vyvgart (efgartigimod alfa) POLICY # 3140P

Criteria

Coverage Criteria for Myasthenia Gravis	
	Diagnosis of generalized myasthenia gravis with positive serological test for anti-AChR antibodies
	Documentation to support a Myasthenia Gravis Foundation of America Clinical Classification of II, III, or IV at the start of therapy
	Documentation to support a Myasthenia Gravis-Activities of Daily Living Score (MG-ADL) score ≥5
	Prescribed by or in consultation with a neurologist or physician that specializes in treatment of generalized myasthenia gravis
	Trial, failure, or contraindication to conventional therapies (i.e. pyridostigmine, immunosuppressant therapies)
	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)	
	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
	Age 18 years or older
	Prescribed by or in consultation with a neurologist
	Documented trial and failure, intolerance or contraindication to corticosteroids
	Documented trial and failure, intolerance or contraindication to a formulary immune globulin product

Exclusion Criteria – Any of the following prevents coverage

Vyvgart will not be covered in addition to Rystiggo, Soliris or Ultomiris

☐ Polyneuropathy of other causes
 Vyvgart Hytrulo is not supported in the treatment of polyneuropathy related to any other condition