Health Alliance™ 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