POLICY Document for VYVGART HYTRULO (efgartigimod alfa and hyaluronidase)

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, and overall, clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Preferred Product
- Policy information specific to preferred medications

Section 2: Site of Care
- Policy information specific to site of care (outpatient, hospital outpatient, home infusion)

Section 3: Clinical Criteria
- Policy information specific to the clinical appropriateness for the medication

Section 1: Preferred Product

CAREFIRST: EXCEPTIONS CRITERIA
COMPLEMENT INHIBITORS

PREFERRED PRODUCTS: ULTOMIRIS, VYVGART, VYVGART HYTRULO

Client Requested: The intent of the criteria is to ensure that patients follow selection elements as established by CareFirst.

POLICY
This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the Complement inhibitor products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Complement Inhibitor Products

	Product(s)
Preferred*	• **Ultomiris** (ravulizumab-cwvz) • **Vyvgart** (efgartigimod alfa) • **Vyvgart** Hytrulo (efgartigimod alfa and hyaluronidase)
Targeted	• **Empaveli** (pegcetacoplan)

	• **Enspryng** (atralizumab-mwge) • **Piasky** (crovalimab) • **Rystiggo** (rozanolixizumab) • **Soliris** (eculizumab) • **Uplizna** (inebilizumab-cdon)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

For Myasthenia Gravis, coverage for the targeted product is provided when member has a documented inadequate response, contraindication, or intolerable adverse event to all the preferred products.

For all other indications, coverage for the targeted product is provided when member has a documented inadequate response, contraindication, or intolerable adverse event to Ultomiris.

Section 2: Site of Care

Site of Care Criteria
Administration of Subcutaneous Vyvgart-Hytrulo (CIDP indication only)

POLICY

I. CRITERIA FOR APPROVAL FOR ADMINISTRATION IN OUTPATIENT HOSPITAL SETTING

This policy provides coverage for administration of Vyvgart-Hytrulo in an outpatient hospital setting for up to 45 days when a member is new to therapy or is reinitiating therapy after not being on therapy for at least 6 months.

This policy provides coverage for administration of Vyvgart-Hytrulo in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

A. The member has experienced an adverse reaction to the drug that did not respond to conventional interventions (eg, acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration.
B. The member is medically unstable (eg respiratory, cardiovascular, or renal conditions).
C. The member has significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the therapy AND the patient does not have access to a caregiver.
D. Alternative administration sites (pharmacy, physician office, ambulatory care, etc.) are greater than 30 miles from the member's home.
E. The member is less than 14 years of age.

For situations where administration of Vyvgart-Hytrulo does not meet the criteria for outpatient hospital administration, coverage for Vyvgart-Hytrulo is provided when administered in alternative sites such as physician office, home infusion or ambulatory care.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the site of care prior authorization review (where applicable):

A. Medical records supporting the member has experienced an adverse reaction that did not respond to conventional interventions or a severe adverse event during or immediately after an administration.
B. Medical records supporting the member is medically unstable
C. Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver
D. Records supporting alternative administration sites are greater than 30 miles from the member's home.
E. Medical records supporting the member is new to therapy.

Section 3: Clinical Criteria

Specialty Guideline Management
Vyvgart-Vyvgart Hytrulo

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Vyvgart	efgartigimod alfa-fcab
Vyvgart Hytrulo	efgartigimod alfa and hyaluronidase-qvfc

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1,2]

Vyvgart is indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

Vyvgart Hytrulo is indicated for the treatment of:

Generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.
Adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP).

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

For initial requests, chart notes, medical records, or claims history documenting:
- Generalized myasthenia gravis:
  - Positive anti-acetylcholine receptor (AChR) antibody test
  - Myasthenia Gravis Foundation of America (MGFA) clinical classification
  - MG activities of daily living score
  - Previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reasons to avoid therapy.
- Chronic inflammatory demyelinating polyneuropathy:
  - Electrodiagnostic testing (e.g., electromyography (EMG), nerve conduction studies (NCS))
  - Previous therapies tried (e.g., immunoglobulins, corticosteroids, or plasma exchange), including response to therapy. If therapy is not advisable, documentation of clinical reasons to avoid therapy.

For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Coverage Criteria

Generalized myasthenia gravis (gMG)[1-5]

Authorization of 6 months may be granted for treatment of generalized myasthenia gravis (gMG) when all of the following criteria are met:

- Anti-acetylcholine receptor (AChR) antibody positive
- Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV
- MG activities of daily living (MG-ADL) total score of greater than or equal to 5
- Meets one of the following:
  - Member has had an inadequate response or intolerable adverse event to at least two immunosuppressive therapies over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, tacrolimus)
  - Member has had an inadequate response or intolerable adverse event to at least one immunosuppressive therapy and intravenous immunoglobulin (IVIG) over the course of at least 12 months
  - Member has a documented clinical reason to avoid therapy with immunosuppressive agents and IVIG

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)

Chronic inflammatory demyelinating polyneuropathy (CIDP) (Vyvgart Hytrulo Only)[2,6]

Authorization of 6 months may be granted for treatment of chronic inflammatory demyelinating polyneuropathy (CIDP) when all of the following criteria are met:

Disease course is progressive or relapsing/remitting for 2 months or longer
Diagnosis was confirmed by electrodiagnostic testing (consistent with EFNS/PNS guidelines)
Meets one of the following:

- Member has had an inadequate response or intolerable adverse event to immunoglobulins, corticosteroids, or plasma exchange
- Member has a documented clinical reason to avoid therapy with immunoglobulins, corticosteroids, or plasma exchange

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment of generalized myasthenia gravis (gMG) in members requesting reauthorization when all of the following criteria are met:

There is no evidence of unacceptable toxicity or disease progression while on the current regimen
Member demonstrates a positive response to therapy (e.g., improvement in MG-ADL score, MG Manual Muscle Test (MMT), MG Composite)
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)

Chronic inflammatory demyelinating polyneuropathy (CIDP) (Vyvgart Hytrulo Only)

Authorization of 12 months may be granted for treatment of chronic inflammatory demyelinating polyneuropathy (CIDP) when all of the following criteria are met:

There is no evidence of unacceptable toxicity or disease progression while on the current regimen
Member demonstrates a positive response to therapy (e.g., improvement in Inflammatory Rasch-built Overall Disability Scale (I-RODS), Inflammatory Neuropathy Cause and Treatment (INCAT) disability scale, Medical Research Council (MRC) Sum score, grip strength)

REFERENCES:

SECTION 1

1. Empaveli [package insert]. Waltham, MA: Apellis Pharmaceuticals, Inc; February 2024.
2. Enspryng [package insert]. San Francisco, CA: Genentech, Inc.; March 2022.
3. Piasky [package insert]. South San Francisco, CA: Genetech Inc; June 2024.
4. Rystiggo [package insert]. Smyrna, GA: UCB, Inc; June 2023.

5. Soliris [package insert]. Boston, MA: Alexion Pharmaceuticals Inc; September 2024.
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7. Uplinza [package insert]. Deerfield, IL: Horizon Therapeutics; July 2021.
8. Vyvgart [package insert]. Boston, MA: argenx US, Inc; August 2024
9. Vyvgart Hytrulo [package insert]. Boston, MA: argenx US, Inc; August 2024

SECTION 2

1. Vyvgart-Hytrulo [package insert]. Boston, MA: Halozyme Therapeutics, Inc.; June 2024.

SECTION 3

1. Vyvgart [package insert]. Boston, MA: Argenx US, Inc.; June 2024.
2. Vyvgart Hytrulo [package insert]. Boston, MA: Argenx US. Inc.; January 2024.
3. Sanders D, Wolfe G, Benatar M et al. International consensus guidance for management of myasthenia gravis. Neurology. 2021; 96 (3) 114-122.
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5. Barnett C, Herbelin L, Dimachkie MM, Barohn RJ. Measuring Clinical Treatment Response in Myasthenia Gravis. Neurol Clin. 2018 May;36(2):339-353.
6. Van den Bergh PY, Hadden RD, van Doorn PA, et al. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy: report of a joint task force of the European Federation of Neurological Societies and the Peripheral Nerve Society – second revision. *Eur J Neurol*. 2021;28(11):3556-3583.