



Drug Coverage Policy

Effective Date.....11/01/2024

Coverage Policy Number.....IP0376

Policy Title.....Vyvgart Intravenous

Neurology – Vyvgart Intravenous

- Vyvgart® (efgartigimod alfa-fcab intravenous infusion – Argenx)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

OVERVIEW

Vyvgart Intravenous, a neonatal Fc receptor blocker, is indicated for the treatment of **generalized myasthenia gravis** in adults who are anti-acetylcholine receptor antibody-positive.¹

Disease Overview

Myasthenia gravis is a chronic autoimmune neuromuscular disease that causes weakness in the skeletal muscles, which are responsible for breathing and moving parts of the body, including the arms and legs.² The hallmark of myasthenia gravis is muscle weakness that worsens after periods of activity and improves after periods of rest. Certain muscles such as those that control eye and eyelid movement, facial expression, chewing, talking, and swallowing are often involved in the disorder; however, the muscles that control breathing, and neck and limb movements may also be

affected. Acquired myasthenia gravis results from the binding of autoantibodies to components of the neuromuscular junction, most commonly the acetylcholine receptor.³

Clinical Efficacy

The efficacy of Vyvgart Intravenous was evaluated in a 26-week, multicenter, randomized, double-blind, placebo-controlled trial in adults with myasthenia gravis (n = 167).⁵ Among other criteria, patients were on stable doses of myasthenia gravis therapy prior to screening (e.g., acetylcholinesterase inhibitors, steroids, or non-steroidal immunosuppressive therapies), either in combination or alone. In addition, patients had a Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV and a Myasthenia Gravis Activities of Daily Living (MG-ADL) total score of ≥ 5 . MG-ADL assesses the impact of generalized myasthenia gravis on daily functions of eight signs or symptoms that are typically impacted by this disease. Each sign or symptom is assessed on a 4-point scale; a higher score indicates greater impairment. Patients were randomized to receive Vyvgart Intravenous or placebo. At baseline, most patients had stable doses of acetylcholinesterase inhibitors (> 80%), steroids (> 70%), and/or non-steroidal immunosuppressive therapies (about 60%). The primary efficacy endpoint was comparison of the percentage of MG-ADL responders during the first treatment cycle between treatment groups in the anti-acetylcholine receptor antibody-positive population. An MG-ADL responder was defined as a patient with a 2-point or greater reduction in the total MG-ADL score compared to the treatment cycle baseline for at least 4 consecutive weeks, with the first reduction occurring no later than 1 week after the last infusion of the cycle. Overall, 67.7% of patients who received Vyvgart Intravenous compared with 29.7% of patients who received placebo were considered MG-ADL responders (P < 0.0001).

Dosing Information

For patients weighing < 120 kg, the recommended dose is 10 mg/kg administered as an intravenous infusion over one hour once weekly for 4 weeks.¹ For patients weighing ≥ 120 kg, the recommended dose is 1200 mg per infusion. Administer subsequent treatment cycles based on clinical evaluation. The safety of initiating subsequent cycles sooner than 50 days from the start of the previous treatment cycle has not been established.

Guidelines

An international consensus guidance for the management of myasthenia gravis was published in 2016.³ The guidelines recommend pyridostigmine for the initial treatment in most patients with myasthenia gravis. The ability to discontinue pyridostigmine can indicate that the patient has met treatment goals and may guide the tapering of other therapies. Corticosteroids or immunosuppressant therapy should be used in all patients with myasthenia gravis who have not met treatment goals after an adequate trial of pyridostigmine. Nonsteroidal immunosuppressant agents include azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, and tacrolimus. It is usually necessary to maintain some immunosuppression for many years, sometimes for life. Plasma exchange and intravenous immunoglobulin can be used as short-term treatments in certain patients. A 2020 update to these guidelines provides new recommendations for methotrexate, rituximab, and Soliris® (eculizumab intravenous infusion).⁴ All recommendations should be considered extensions or additions to recommendations made in the initial international consensus guidance. Oral methotrexate may be considered as a steroid-sparing agent in patients with generalized myasthenia gravis who have not tolerated or responded to steroid-sparing agents. Rituximab should be considered as an early therapeutic option in patients with anti-muscle specific tyrosine kinase antibody-positive myasthenia gravis who have an unsatisfactory response to initial immunotherapy. Soliris should be considered in the treatment of severe, refractory, anti-acetylcholine receptor antibody-positive generalized myasthenia gravis.

Medical Necessity Criteria

Vyvgart Intravenous is considered medically necessary when the following criteria are met:

FDA-Approved Indication

1. Generalized Myasthenia Gravis. Approve if the patient meets ONE of the following (A or B):

- A) Initial Therapy.** Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):
- i.** Patient is \geq 18 years of age; AND
 - ii.** Documentation that the patient has confirmed anti-acetylcholine receptor antibody positive generalized myasthenia gravis; AND
 - iii.** Patient meets BOTH of the following (a and b):
 - a)** Myasthenia Gravis Foundation of America classification of II to IV; AND
 - b)** Myasthenia Gravis Activities of Daily Living (MG-ADL) score of \geq 5; AND
 - iv.** Patient meets ONE of the following (a or b):
 - a)** Patient received or is currently receiving pyridostigmine; OR
 - b)** Patient has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine; AND
 - v.** Patient has evidence of unresolved symptoms of generalized myasthenia gravis; AND
Note: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (e.g., double vision, talking, impairment of mobility); AND
 - vi.** Treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle; AND
 - vii.** The medication is being prescribed by or in consultation with a neurologist.
- B) Patient is Currently Receiving Vyvgart Intravenous (or Vyvgart Hytrulo [efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection]).** Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
- i.** Patient is \geq 18 years of age; AND
 - ii.** According to the prescriber, patient is continuing to derive benefit from Vyvgart Intravenous (or Vyvgart Hytrulo); AND
Note: Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function.
 - iii.** Treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle; AND
 - iv.** The medication is being prescribed by or in consultation with a neurologist.

Dosing. Approve if the patient meets BOTH of the following dosing regimens (A and B):

- A) Patient meets ONE of the following (i or ii):**
- i.** Patient < 120 kg: The dose is 10 mg/kg administered by intravenous infusion once weekly for 4 weeks; OR
 - ii.** Patient \geq 120 kg: The dose is 1,200 mg administered by intravenous infusion once weekly for 4 weeks; AND
- B) Treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle.**

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 1. Concomitant Use with Another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab Product.** There is no evidence to support concomitant use of Vyvgart Intravenous with another neonatal Fc receptor blocker, a complement inhibitor, or a rituximab product.

Note: Examples of neonatal Fc receptor blockers are Rystiggo (rozanolixizumab-noli subcutaneous infusion) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection).

Note: Examples of complement inhibitors are Soliris (eculizumab intravenous infusion), Ultomiris (ravulizumab-cwvz intravenous infusion), and Zilbrysq (zilucoplan subcutaneous injection).

Coding Information

- 1) This list of codes may not be all-inclusive.
- 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPSC Codes	Description
J9332	Injection, efgartigimod alfa-fcab, 2 mg

References

1. Vyvgart® intravenous infusion [prescribing information]. Boston, MA: Argenx; January 2024.
2. National Institute of Neurological Disorders and Stroke (NINDS). Myasthenia Gravis Fact Sheet. National Institutes of Health (NIH) Publication No. 17-768. Publication last updated: March 2020. Available at: https://www.ninds.nih.gov/sites/default/files/migrate-documents/myasthenia_gravis_e_march_2020_508c.pdf. Accessed on July 15, 2024.
3. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. *Neurology*. 2016;87:419-425.
4. Narayanaswami P, Sanders DB, Wolfe G, et al. International Consensus Guidance for Management of Myasthenia Gravis: 2020 Update. *Neurology*. 2021 Jan 19;96(3):114-122.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	Policy Name: Updated title from "Efgartigimod Intravenous" to "Neurology – Vyvgart Intravenous." Generalized Myasthenia Gravis: Added criterion to <u>Initial therapy</u> and <u>Patient is currently receiving</u> section: "Treatment cycles are no	11/01/2024

	more frequent than every 50 days from the start of the previous treatment cycle." Removed "prior to starting therapy with Vyvgart or Vyvgart Hytrulo" from requirement that patient has MGFA clinical classification of II-IV and MG-ADL score of 5 or higher.	
--	---	--

The policy effective date is in force until updated or retired.

"Cigna Companies" refers to operating subsidiaries of The Cigna Group. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of The Cigna Group. © 2024 The Cigna Group.