Pharmacy Policy Bulletin: J-1450 Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) – Commercial and Healthcare Reform	
Number: J-1450	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** **Commercial:** **Prior Authorization (1.):** 1. Miscellaneous Specialty Injectable= Yes w/ Prior Authorization **Healthcare Reform:** Not Aapplicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	**Additional Restriction(s):** None
Version: J-1450-001	**Original Date:** 06/25/2025
Effective Date: 07/18/2025	**Review Date:** 06/25/2025

Drugs Product(s):	• Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) prefilled syringe

FDA-Approved Indication(s):	• Treatment of adult patients with:
	  ○ Generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody positive
	  ○ Chronic inflammatory demyelinating polyneuropathy (CIDP)

Background:	• Efgartigimod alfa is a human IgG1 antibody fragment that binds to the neonatal Fc receptor (FcRn), resulting in the reduction of circulating IgG.
	• Vyvgart Hytrulo is a combination of Vyvgart and hyaluronidase, an endoglycosidase. The hyaluronidase is used to increase the dispersion and absorption of the Vyvgart when administered subcutaneously. Hyaluronidase increases permeability of the subcutaneous tissue by depolymerizing hyaluronan. This effect is transient and permeability of the subcutaneous tissue is restored within 24 to 48 hours.
	• **Myasthenia gravis (MG)**
	  ○ MG is an autoimmune disease characterized by muscle weakness and muscle fatigue. There are two clinical forms of MG, ocular MG and gMG. In gMG, weakness involves ocular muscles and a variable combination of the arms, legs, and respiratory muscles. The specific cause of MG is unknown but may involve an abnormality in the thymus. The prevalence of MG is approximately 14 to 20 cases per 100,000 individuals in the United States. AChR antibody positive (AChR-Ab+) MG patients have antibodies which are inappropriately directed against acetylcholine receptors, causing a decrease in acetylcholine receptors, failure of nerve transition at neuromuscular junctions, and deficiency or weakness of muscle contractions. Approximately 85% of patients with gMG are AChR-Ab+; approximately 6% have antibodies against the muscle-specific tyrosine kinase (MuSK).
	  ○ The 2016 International Consensus Guidance for Management of Myasthenia Gravis recommends pyridostigmine as initial therapy for

most patients with MG. Corticosteroids or immunosuppressant therapy should be used in all MG patients who have not met treatment goals after an adequate trial of pyridostigmine.
    - Additional recommendations in the 2021 International Consensus Guidance for Management of Myasthenia Gravis include recommendations for thymectomy in AChR-Ab+ gMG patients early in the disease or after failure of an initial adequate trial of immunotherapy. Rituximab is an option if patients fail or do not tolerate other immunosuppressive agents; however, the efficacy is uncertain. Oral methotrexate may be considered as a steroid-sparing agent in patients with gMG who have not tolerated or responded to steroid-sparing agents that are better supported by randomized controlled trial data. Soliris should be considered in the treatment of severe, refractory, anti-AChR-Ab+ gMG. Soliris should be considered after trials of other immunotherapies.
    - Mestinon (pyridostigmine bromide), a cholinesterase inhibitor, is FDA-approved for the treatment of MG. Pyridostigmine, a cholinesterase inhibitor offers symptomatic therapy by retarding the degradation of acetylcholine (ACh) in the neuromuscular junction resulting in prolonging the effect of ACh. Pyridostigmine, available as oral tablets, extended-release tablets, and as an oral suspension, is recommended as the initial treatment in most patients with MG.
    - Although some patients do well on long-term pyridostigmine alone, most patients with generalized MG require additional therapy directed at the underlying immune dysregulation at some point in their illness, if not indefinitely.
    - Other medications frequently used off-label for MG include rituximab, steroids, intravenous immunoglobulin (IVIG), and immunosuppressants such as azathioprine, cyclosporine, and mycophenolate.
- **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)**
    - CIDP is a neurological disorder characterized by progressive weakness and impaired sensory function in the legs and arms. CIDP is caused by damage to the myelin sheath of the peripheral nerve. Treatment includes corticosteroids (for example., daily oral prednisone or prednisolone, pulsed oral dexamethasone, or pulsed intravenous methylprednisolone), immunosuppressants, plasmapheresis, and/or an immune globulin.
    - The diagnosis of CIDP should be considered in patients with symmetric or asymmetric polyneuropathy who have a progressive or relapsing-remitting clinical course for more than two months, particularly if the clinical features include positive sensory symptoms, proximal weakness, or areflexia. Electrophysiologic testing developed by the European Federation of Neurological Societies and the Peripheral Nerve Society (EFNS/PNS) is necessary to confirm the diagnosis.
- Prescribing Considerations:
    - Evaluate the need to administer age-appropriate vaccines according to immunization guidelines before initiation of a new treatment cycle with Vyvgart Hytrulo.
    - Vyvgart Hytrulo single-dose vial is administered by a healthcare professional only, while the prefilled syringe may be self-administered.
    - Closely monitor for reduced effectiveness of medications that bind to the human neonatal Fc receptor (for example, immunoglobulin products, monoclonal antibodies, IgG antibody derivatives with the human Fc domain). When concomitant long-term use of such medications is essential for patient care, consider discontinuing Vyvgart Hytrulo and using alternative therapies.

	○ MG ▪ Vyvgart Hytrulo is administered once weekly for 4 weeks. Vyvgart Hytrulo has a fixed dose. Vyvgart Hytrulo single-dose vial is administered as a subcutaneous injection over 30 to 90 seconds, while the prefilled syringe is administered as a subcutaneous injection over approximately 20 to 30 seconds. ▪ Subsequent treatment cycles are administered 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. ○ CIDP ▪ Vyvgart without hyaluronidase is not indicated for CIDP. ▪ The recommended dosage is 1,008 mg / 11,200 units (1,008 mg efgartigimod alfa and 11,200 units hyaluronidase) as once weekly injections for both the single-dose vial and prefilled syringe. ▪ Vyvgart Hytrulo single-dose vial is administered as a subcutaneous injection over 30 to 90 seconds, while the prefilled syringe is administered as a subcutaneous injection over approximately 20 to 30 seconds.

Approval Criteria

I. Generalized myasthenia gravis (gMG)

A. Initial Authorization

When a benefit, coverage of Vyvgart Hytrulo may be approved when all of the following criteria are met **(1. through 7.)**:

1. The member is 18 years of age and older.
2. The member has a diagnosis of generalized myasthenia gravis (gMG) (ICD-10: G70).
3. The member is anti-acetylcholine receptor (AChR) antibody positive (Ab+).
4. The member meets the Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV.
5. The member has a Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score of five (5) or greater at initiation.
6. The member has experienced therapeutic failure or intolerance to at least two (2) different agents from two different classes, used alone or in combination, or contraindication to all **(a., b., or c.)**:
   a. Acetylcholinesterase inhibitors
   b. Systemic steroids
   c. Non-steroidal immunosuppressants (for example: azathioprine, cyclosporine, methotrexate, tacrolimis, and mycophenolate)
7. The member is not concurrently receiving a complement inhibitor (for example, Soliris, Ultomiris, Zilbrysq or IVIG) within four (4) weeks of starting Vyvgart Hytrulo.

B. Reauthorization

When a benefit, coverage of Vyvgart Hytrulo may be approved when one (1) of the following criteria are met **(1. or 2.)**:

1. The member has experienced improvement in signs and symptoms of gMG (for example, speech, swallowing, mobility, and/or respiratory function).
2. The member has experienced a decrease in the number of exacerbations of gMG.

II. Chronic inflammatory demyelinating polyneuropathy (CIDP)

A. Initial Authorization

When a benefit, coverage of Vyvgart Hytrulo may be approved when all of the following criteria are met **(1. through 4.)**

1. The member is 18 years of age and older.

2. The member has a diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) (ICD-10: 61.81).

3. The diagnosis is supported by all of the following **(a. through d.)**:

- **a.** The member has experienced progressive symptoms for at least two (2) months.
- **b.** The member has progressive or relapsing motor sensory dysfunction of more than one (1) limb or a peripheral nerve nature, developing over at least two (2) months.
- **c.** The member has hypo- or areflexia (this will usually involve all four (4) limbs).
- **d.** The member has nerve conduction studies strongly supportive of demyelination, and meets one (1) of the following **(i. through vii.)**:
  - **i.** Motor distal latency prolongation in at least two (2) nerves
  - **ii.** Reduction of motor conduction velocity in at least two (2) nerves
  - **iii.** Prolongation of F-wave latency in at least two (2) nerves
  - **iv.** Absence of F-waves in at least two (2) nerves
  - **v.** Motor conduction block in at least one (1) nerve
  - **vi.** Abnormal temporal dispersion in at least two (2) nerves
  - **vii.** Distal CMAP duration prolongation in at least one (1) nerve

4. The member has experienced therapeutic failure or intolerance to one (1) of the following or contraindication to all **(a. or b.):**

- **a.** Systemic corticosteroids
- **b.** An immune globulin (for example, IVIG or subcutaneous immunoglobulin)

A. Reauthorization

When a benefit, reauthorization of Vyvgart Hytrulo may be approved when the following criterion is met **(1.)**:

1. The member has experienced improvement in their functional ability or strength from baseline.

III. An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations .

Limitations of Coverage

I. Coverage of drug(s) addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.

II. For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

Authorization Duration

- **Generalized myasthenia gravis (gMG)**
  - **Initial Authorization:**
    - Commercial and HCR Plans**:** If approved, a 6 month authorization will be granted.
  - **Reauthorization:**
    - Commercial and HCR Plans: If approved, a 12 month authorization will be granted.
- **Chronic inflammatory demyelinating polyneuropathy (CIDP)**

- Commercial and HCR Plans: If approved, a 12 month authorization will be granted

Automatic Approval Criteria

None

References:

1. Vyvgart Hytrulo [package insert]. Boston, MA: Argenx US, Inc.; April 2025.
2. Van den Bergh PY, Hadden RD, Bouche P, 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 - first revision. *Eur J Neurol*. 2010;17(3):356-63.
3. van Lieverloo GGA, Peric S, Doneddu PE, et al. Corticosteroids in chronic inflammatory demyelinating polyneuropathy: A retrospective, multicentre study, comparing efficacy and safety of daily prednisolone, pulsed dexamethasone, and pulsed intravenous methylprednisolone. *J Neurol*. 2018;265(9):2052-2059.
4. DRUGDEX System (Micromedex 2.0). Greenwood Village, CO: Truven Health Analytics; 2025.
5. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. *Neurology*. 2016;87(4):419-425.
6. Narayanaswami P, Sanders D, Wolfe G, et al. International Consensus Guidance for Management of Myasthenia Gravis. *Neurology*. 2021;96(3):114-122.