

# Vyvgart® (Efgartigimod Alfa-Fcab)

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[Instructions for Use](#)

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|-----------------------------------------------------------------------------------------------------|
| Commercial Policy                                                                                   |
| <ul style="list-style-type: none"> <li><a href="#">Vyvgart® (Efgartigimod Alfa-Fcab)</a></li> </ul> |

## Application

This Medical Benefit Drug Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

| State          | Policy/Guideline                                                                           |
|----------------|--------------------------------------------------------------------------------------------|
| Arizona        | Refer to the state's Medicaid clinical policy                                              |
| Florida        | Refer to the state's Medicaid clinical policy                                              |
| Indiana        | <a href="#">Vyvgart® (Efgartigimod Alfa-Fcab) (for Indiana Only)</a>                       |
| Kansas         | Refer to the state's Medicaid clinical policy                                              |
| Louisiana      | <a href="#">Vyvgart® (Efgartigimod Alfa-Fcab) (for Louisiana Only)</a>                     |
| North Carolina | None                                                                                       |
| Texas          | Refer to drug specific criteria found within the Texas Medicaid Provider Procedures Manual |

## Coverage Rationale

### Myasthenia Gravis

Vyvgart® is proven and medically necessary for the treatment of generalized myasthenia gravis when all of the following criteria are met:

- Initial Therapy:
  - Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of generalized myasthenia gravis (gMG) by a neurologist or in consultation with a neurologist confirming all of the following:
    - Patient has not failed a previous course of Vyvgart® therapy; and
    - Positive serologic test for anti-AChR antibodies; and
    - One of the following:
      - History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation; or
      - History of positive anticholinesterase test, e.g., edrophonium chloride test; or

- Patient has demonstrated improvement in MG signs on oral cholinesterase inhibitors as assessed by the treating neurologist
- and
- Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; and
- Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score  $\geq 5$  at initiation of therapy
- and
- One of the following:
  - History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, methotrexate, cyclosporine, mycophenolate, etc.); or
  - Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control
- and
- Patient is not receiving Vyvgart<sup>®</sup> in combination with Soliris (eculizumab) or Ultomiris (ravulizumab); and
- Vyvgart<sup>®</sup> is initiated and titrated according to the U.S. FDA labeled dosing for gMG, up to a maximum of 1,200 mg per dose; and
- Prescribed by or in consultation with a neurologist; and
- Initial authorization will be for no more than 6 months.
- Continuation of Therapy:
  - Patient has previously been treated with Vyvgart<sup>®</sup>; and
  - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by at least all of the following:
    - Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline<sup>6</sup>.
    - Reduction in signs and symptoms of myasthenia gravis
    - Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Vyvgart<sup>®</sup>. Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Vyvgart<sup>®</sup> therapy will be considered as treatment failure.
  - and
  - Patient is not receiving Vyvgart<sup>®</sup> in combination with Soliris (eculizumab) or Ultomiris (ravulizumab); and
  - Vyvgart<sup>®</sup> is dosed according to the U.S. FDA labeled dosing for gMG: up to a maximum of 1,200 mg per dose; and
  - Prescribed by or in consultation with a neurologist; and
  - Reauthorization will be for no more than 12 months.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| HCPCS Code | Description                             |
|------------|-----------------------------------------|
| J9332      | Injection, efgartigimod alfa-fcab, 2 mg |

| Diagnosis Code | Description                                    |
|----------------|------------------------------------------------|
| G70.00         | Myasthenia gravis without (acute) exacerbation |

## Background

Efgartigimod alfa-fcab is a human IgG1 antibody fragment that binds to the neonatal Fc receptor (FcRn), resulting in the reduction of circulating IgG. The pharmacological effect of efgartigimod alfa-fcab was assessed by measuring the decrease in serum IgG levels and AChR autoantibody levels. In patients testing positive for AChR antibodies and who were treated with efgartigimod alfa-fcab, there was a reduction in total IgG levels relative to baseline. Decrease in AChR autoantibody levels followed a similar pattern.

## Clinical Evidence

### Generalized Myasthenia Gravis

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

The efficacy of efgartigimod alfa-fcab for the treatment of generalized myasthenia gravis (gMG) in adults who are AChR antibody positive was established in a 26-week, multi-center, randomized, double-blind, placebo-controlled trial (Study 1; NCT03669588).

Study 1 enrolled patients who met the following criteria at screening:

- Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV
- MG-Activities of Daily Living (MG-ADL) total score of  $\geq 5$
- On a stable dose of MG therapy prior to screening that included acetylcholinesterase (AChE) inhibitors, steroids, or non-steroidal immunosuppressive therapies (NSISTs), either in combination or alone
- IgG levels of at least 6 g/L

A total of 167 patients were enrolled in Study 1 and were randomized to receive either efgartigimod alfa-fcab 10 mg/kg (1,200 mg for those weighing 120 kg or more) (n = 84) or placebo (n = 83). Baseline characteristics were similar between treatment groups. Patients had a median age of 46 years at screening (range: 19 to 81 years) and a median time since diagnosis of 9 years. Seventy-one percent were female and 84% were White. Median MG-ADL total score was 9, and median Quantitative Myasthenia Gravis (QMG) total score was 16. The majority of patients (n = 65 for efgartigimod alfa-fcab, n = 64 for placebo) were positive for AChR antibodies.

At baseline, over 80% of patients in each group received AChE inhibitors, over 70% in each treatment group received steroids, and approximately 60% in each treatment group received NSISTs at stable doses.

Patients were treated with efgartigimod alfa-fcab at the recommended dosage regimen.

The efficacy of efgartigimod alfa-fcab was measured using the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) which assesses the impact of gMG on daily functions of 8 signs or symptoms that are typically affected in gMG. Each item is assessed on a 4-point scale where a score of 0 represents normal function and a score of 3 represents loss of ability to perform that function. A total score ranges from 0 to 24 with the higher scores indicating more impairment. In this study, 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.

The primary efficacy endpoint was the comparison of the percentage of MG-ADL responders during the first treatment cycle between treatment groups in the AChR-Ab positive population. A statistically significant difference favoring efgartigimod alfa-fcab was observed in the MG-ADL responder rate during the first treatment cycle [67.7% in the efgartigimod alfa-fcab-treated group vs. 29.7% in the placebo-treated group ( $p < 0.0001$ )].

The efficacy of efgartigimod alfa-fcab was also measured using the Quantitative Myasthenia Gravis (QMG) total score which is a 13-item categorical grading system that assesses muscle weakness. Each item is assessed on a 4-point scale where a score of 0 represents no weakness and a score of 3 represents severe weakness. A total possible score ranges from 0 to 39 (higher scores indicate more severe impairment). In this study a QMG responder was defined as a patient who had a 3 point or greater

reduction in the total QMG score compared to the treatment cycle baseline for at least 4 consecutive weeks, with the first reduction occurring no later than 1 week after last infusion of the cycle.

The secondary endpoint was the comparison of the percentage of QMG responders during the first treatment cycle between both treatment groups in the AChR-Ab positive patients. A statistically significant difference favoring Vyvgart® was observed in the QMG responder rate during the first treatment cycle [63.1% in the efgartigimod alfa-fcab-treated group vs. 14.1% in the placebo-treated group ( $p < 0.0001$ )].

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

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

## References

1. Vyvgart® [prescribing information]. Boston, MA: argenx U.S., Inc.; April 2022.
2. Howard JF, Jr., Bril V, Vu T, et al. Safety, efficacy, and tolerability of efgartigimod in patients with generalized myasthenia gravis (ADAPT): a multicenter, randomized, placebo-controlled, phase 3 trial. *The Lancet Neurology*. 2021;20(7):526-536.
3. Bird S. Overview of the treatment of myasthenia gravis. In: *UpToDate*, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on January 6, 2022).
4. Farmakidis C, Pasnoor M, Dimachkie MM, Barohn RJ. Treatment of Myasthenia Gravis. *Neurol Clin*. 2018;36(2):311-337.
5. Narayanaswami P, Sanders DB, Wolfe G, et al. International Consensus Guidance for Management of Myasthenia Gravis: 2020 Update. *Neurology*. 2021;96(3):114-122.
6. Muppidi S, Silvestri NJ, Tan R, Riggs K, Leighton T, Phillips GA. Utilization of MG-ADL in myasthenia gravis clinical research and care. *Muscle Nerve*. 2022;65(6):630-639. doi:10.1002/mus.27476.

## Policy History/Revision Information

| Date       | Summary of Changes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/01/2022 | <p><b>Application</b></p> <p><b>Arizona</b></p> <ul style="list-style-type: none"><li>• Added language to indicate this Medical Benefit Drug Policy does not apply to the state of Arizona; refer to the state's Medicaid clinical policy</li></ul> <p><b>Texas</b></p> <ul style="list-style-type: none"><li>• Added language to indicate this Medical Benefit Drug Policy does not apply to the state of Texas; refer to the drug specific criteria found within the <i>Texas Medicaid Provider Procedures Manual</i></li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>• Archived previous policy version CS2022D00111E</li></ul> |

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.