Clinical Policy: Efgartigimod Alfa-fcab, Efgartigimod/Hyaluronidase-qvfc (Vyvgart, Vyvgart Hytrulo)

Reference Number: CP.PHAR.555
Effective Date: 12.17.21
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

- Efgartigimod alfa-fcab (Vyvgart®) is a neonatal Fc receptor (FcRn) antagonist.
- Efgartigimod alfa/hyaluronidase-qvfc (Vyvgart® Hytrulo) is a combination of efgartigimod alfa, a neonatal Fc receptor blocker, and hyaluronidase, an endoglycosidase.

FDA Approved Indication(s)

Vyvgart and Vyvgart Hytrulo are indicated for the treatment of adult patients with generalized myasthenia gravis (gMG).

Vyvgart Hytrulo is also indicated for the treatment of adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Vyvgart and Vyvgart Hytrulo are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Generalized Myasthenia Gravis (must meet all)**:**

1. Diagnosis of gMG;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. Myasthenia Gravis-Activities of Daily Living (MG-ADL) score ≥ 5 at baseline;
5. Greater than 50% of the baseline MG-ADL score is due to non-ocular symptoms;
6. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV;
7. Serologic tests show one of the following (a or b):
   a. Member has positive serologic test for one of the following (i, ii, or iii):
      i. Anti-acetylcholine receptor (AChR) antibodies;
      ii. Anti-muscle specific tyrosine kinase (MuSK) antibodies;
      iii. Anti-low-density lipoprotein receptor-related protein 4 (LRP4) antibodies;
   b. Member has triple seronegative disease (i.e., anti-AChR, anti-MuSK, and anti-LRP4 antibody negative);

8. If member has positive serologic test for anti-AChR antibodies: Failure of a cholinesterase inhibitor (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
9. Failure of a corticosteroid (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;*
   **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
10. Failure of at least one non-steroidal immunosuppressive therapy (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;*
    **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395*
11. The requested agent is not prescribed concurrently with Uplizna®, a complement inhibitor (e.g., Soliris®/Bkemv™/Epysqli®, Ultomiris®, Zilbrysq®), or another FcRn antagonist (e.g., Imaavy™, Rystiggo®);
12. For Vyvgart requests: Documentation of member's current weight (in kg);
13. Request meets one of the following (a or b):
    a. Vyvgart: Dose does not exceed 10 mg/kg (1,200 mg per infusion for members weighing 120 kg or more) IV once weekly for the first 4 weeks of every 8-week cycle;
    b. Vyvgart Hytrulo: Dose does not exceed 1,008 mg/11,200 units SC once weekly for the first 4 weeks of every 8-week cycle.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Chronic Inflammatory Demyelinating Polyneuropathy (must meet all)**:**
1. Request is for Vyvgart Hytrulo;
2. Diagnosis of CIDP;
3. Prescribed by or in consultation with a neurologist or neuromuscular specialist;
4. Age ≥ 18 years;
5. Disease is progressive or relapsing for ≥ 2 months;
6. Member has either of the following (a or b):
   a. Both of the following, characterizing typical CIDP (i and ii):
      i. Progressive or relapsing symmetric, proximal, and distal muscle weakness of upper and lower limbs, and sensory involvement of ≥ 2 limbs;
      ii. Absent or reduced tendon reflexes in all limbs;
   b. One of the following CIDP variants (i-v):
      i. Distal CIDP;
      ii. Multifocal CIDP;
      iii. Focal CIDP;
      iv. Motor CIDP;
      v. Sensory CIDP;
7. Diagnosis has been confirmed via electrodiagnostic testing;

8. Member does not have any of the following (a-f):
   a. Borrelia burgdorferi infection (Lyme disease), diphtheria, or drug or toxin exposure probable to have caused the neuropathy;
   b. Hereditary demyelinating neuropathy;
   c. Prominent sphincter disturbance;
   d. Multifocal motor neuropathy;
   e. IgM monoclonal gammopathy with high titer antibodies to myelin-associated glycoprotein;
   f. Other causes for a demyelinating neuropathy, including POEMS syndrome, osteosclerotic myeloma, and diabetic and nondiabetic lumbosacral radiculoplexus neuropathy;
9. Insufficient response to ≥ 3 months of at least one immune globulin therapy* (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;^
   **Prior authorization may be required for immune globulins*
   ^For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395
10. For members who do not have pure motor symptoms, failure of a corticosteroid (e.g., dexamethasone) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;^
    ^For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395
11. Vyvgart Hytrulo is not prescribed concurrently with immune globulin therapy, a complement inhibitor (e.g., Soliris/Bkemv/Epysqli, Ultomiris), or another FcRn antagonist (e.g., Rystiggo);
12. Dose does not exceed 1,008 mg/11,200 units SC once weekly.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Generalized Myasthenia Gravis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by a ≥ 2-point reduction in MG-ADL total score;
3. The requested agent is not prescribed concurrently with Uplizna, a complement inhibitor (e.g., Soliris/Bkemv/Epysqli, Ultomiris, Zilbrysq) or another FcRn antagonist (e.g., Imaavy, Rystiggo);
4. For Vyvgart requests: Documentation of member's current weight (in kg);
5. If request is for a dose increase, request meets one of the following (a or b):
   a. Vyvgart: New dose does not exceed 10 mg/kg (1,200 mg per infusion for members weighing 120 kg or more) IV once weekly for the first 4 weeks of every 8-week cycle;
   b. Vyvgart Hytrulo: New dose does not exceed 1,008 mg/11,200 units SC once weekly for the first 4 weeks of every 8-week cycle.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Chronic Inflammatory Demyelinating Polyneuropathy (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Request is for Vyvgart Hytrulo;
3. Member is responding positively to therapy as evidenced by one of the following (a, b, or c):
   a. Improvement or stabilization in a CIDP disability or impairment scale (*see Appendix E for scales*);
   b. Disability improvement;
   c. Symptom improvement in affected limbs;
4. Vyvgart Hytrulo is not prescribed concurrently with immune globulin therapy, a complement inhibitor (e.g., Soliris/Bkemv/Epysqli, Ultomiris), or another FcRn antagonist (e.g., Rystiggo);
5. If request is for a dose increase, new dose does not exceed 1,008 mg/11,200 units SC once weekly.

Approval duration:
Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to the member's renewal date, whichever is longer

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AChR: acetylcholine receptor
CIDP: chronic inflammatory demyelinating polyneuropathy
EAN/PNS: European Academy of Neurology/Peripheral Nerve Society
FcRn: neonatal Fc receptor
FDA: Food and Drug Administration
gMG: generalized myasthenia gravis
IgG: immunoglobulin G
INCAT: inflammatory neuropathy cause and treatment
LRP4: low-density lipoprotein receptor-related protein 4
MG-ADL: Myasthenia Gravis-Activities of Daily Living
MGFA: Myasthenia Gravis Foundation of America
MuSK: muscle specific tyrosine kinase

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Corticosteroids		
betamethasone	**gMG**	7.2 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Oral: 0.6 to 7.2 mg PO per day	
dexamethasone	**gMG** Oral: 0.75 to 9 mg/day PO **CIDP** Oral: 40 mg QD x 4 days repeated q 4 weeks	Varies
methylprednisolone	**gMG** Oral: 12 to 20 mg PO per day; increase as needed by 4 mg every 2-3 days until there is marked clinical improvement **CIDP** Oral/IV: 500 mg QD x 4 days repeated q 4 weeks (pulsed regimen)	Varies
prednisone	**gMG** Oral: 15 mg/day to 20 mg/day; increase by 5 mg every 2-3 days as needed	60 mg/day
prednisolone	**CIDP** Oral: 30 mg QD x 4 weeks followed by slow tapering over months	Varies
Cholinesterase Inhibitors for gMG		
pyridostigmine (Mestinon®)	Oral immediate-release: 600 mg daily in divided doses (range, 60-1,500 mg daily in divided doses) Oral sustained release: 180-540 mg QD or BID	Immediate-release: 1,500 mg/day Sustained-release:1,080 mg/day
neostigmine (Bloxiverz®)	Oral: 15 mg TID. The daily dosage should be gradually increased at intervals of 1 or more days. The usual maintenance dosage is 15-375 mg/day (average 150 mg) IM or SC: 0.5 mg based on response to therapy	Oral: 375 mg/day
Non-Steroidal Immunosuppressants for gMG		
azathioprine (Imuran®)	Oral: 50 mg QD for 1 week, then increase gradually to 2 to 3 mg/kg/day	3 mg/kg/day
mycophenolate mofetil (Cellcept®)*	Oral: Dosage not established. 1 gram BID has been used with adjunctive corticosteroids or other non-steroidal immunosuppressive medications	2 g/day
cyclosporine (Sandimmune®)*	Oral: initial dose of cyclosporine (non-modified), 5 mg/kg/day in 2 divided doses	5 mg/kg/day
Rituxan® (rituximab), Riabni™ (rituximab-arrx), Ruxience™ (rituximab-pvvr),	IV: 375 mg/m^2 once a week for 4 weeks; an additional 375 mg/m^2 dose may be given every 1 to 3 months afterwards	375 mg/m^2

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Truxima® (rituximab-abbs)*†		
Immune Globulins for CIDP		
intravenous immune globulin (e.g., Gammagard Liquid®, Gamunex®-C, Gammaked™)	Induction: 2 g/kg divided over 2-5 days Maintenance: 1 g/kg q 3 weeks	Not applicable
subcutaneous immune globulin (e.g., Hizentra®, HyQvia®)	Varies	Not applicable

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label; †Prior authorization is required for rituximab products*

Appendix C: Contraindications/Boxed Warnings

- Contraindications:
  - Vyvgart and Vyvgart Hytrulo: serious hypersensitivity to efgartigimod alfa products or to any of the excipients of the drug
  - Vyvgart Hytrulo: serious hypersensitivity to hyaluronidase

Appendix D: General Information

- gMG
  - The MG-ADL scale is an 8-item patient-reported scale that measures functional status in 8 domains related to MG – talking, chewing, swallowing, breathing, impairment of ability to brush teeth or comb hair, impairment of ability to arise from a chair, double vision, and eyelid droop. Each domain is given a score of 0-3, with 0 being normal and 3 being most severe impairment. A 2-point decrease in the MG-ADL score is considered a clinically meaningful response.
  - In the Phase 3 ADAPT trial, all study patients received an initial 4-week treatment cycle of Vyvgart, with subsequent cycles administered according to individual clinical response when MG-ADL score was ≥ 5 (i.e., symptoms are at least the minimum threshold required for necessitating treatment) and, if the patient was an MG-ADL responder to the 4-week treatment cycle, when they no longer had a clinically meaningful decrease (MG-ADL clinically meaningful improvement defined as having ≥ 2-point improvement in total MG-ADL score) compared with baseline. Subsequent cycles could commence no sooner than 8 weeks from initiation of the previous cycle.
- CIDP
  - CIDP is divided into typical CIDP and CIDP variants. CIDP variants are now well characterized entities, each presenting with a specific clinical and electrodiagnostic phenotype.
  - Diagnostic criteria for CIDP: If the electrodiagnostic study does not fulfill the minimal electrodiagnostic criteria (i.e., conclusion is "possible CIDP"), then ≥ 2

additional supportive criteria can be met for some CIDP variants. Supportive criteria include response to CIDP standard treatment, cerebrospinal fluid analysis, nerve imaging, and nerve biopsy. Not all CIDP diagnostic categories allow for 2 supportive criteria to meet for CIDP diagnosis and hence were not included in the Vyvgart Hytrulo CIDP criteria. For diagnostic criteria specific to each of the CIDP variants, refer to the 2021 EAN/PNS CIDP guideline.

- Immune globulins, corticosteroids, and plasma exchange are recommended treatments for patients with disabling symptoms. Plasma exchange is similarly effective to immune globulins and corticosteroids but is typically reserved for treatment-refractory patients; it may be less well tolerated and more difficult to administer. Patient-specific factors may determine the appropriate choice of therapy.

Appendix E: Examples of CIDP Disability and Impairment Scales

- Inflammatory neuropathy cause and treatment (INCAT) disability score
- Inflammatory Rasch-built overall disability scale (I-RODS)
- Modified INCAT sensory sum scale (mISS)
- Medical Research Council (MRC) sum score
- Grip strength (with Martin Vigorimeter or Jamar hand grip dynamometer)

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Efgartigimod alfa-fcab (Vyvgart)	gMG	10 mg/kg IV once weekly for the first 4 weeks. Subsequent treatment cycles based on clinical evaluation.	10 mg/kg/week (1,200 mg per infusion for members weighing ≥ 120 kg)
Efgartigimod alfa/ hyaluronidase-qvfc (Vyvgart Hytrulo)	gMG	Syringe: 1,000 mg efgartigimod alfa and 10,000 units hyaluronidase SC once weekly injections for the first 4 weeks Vial: 1,008 mg efgartigimod alfa and 11,200 units hyaluronidase SC once weekly for the first 4 weeks. Subsequent treatment cycles based on clinical evaluation.	Syringe: 1,000 mg/10,000 units/week Vial: 1,008 mg/11,200 units/week
	CIDP	Syringe: 1,000 mg efgartigimod alfa and 10,000 units hyaluronidase SC once weekly Vial:	

Drug Name	Indication	Dosing Regimen	Maximum Dose
		1,008 mg efgartigimod alfa and 11,200 units hyaluronidase SC once weekly	

VI. Product Availability

Drug Name	Availability
Efgartigimod alfa-fcab (Vyvgart)	Single-dose vial: 400 mg/20 mL injection solution
Efgartigimod alfa-hyaluronidase-qvfc (Vyvgart Hytrulo)	• Single-dose vial: 1,008 mg (efgartigimod alfa)/11,200 units (hyaluronidase)/5.6 mL • Single-dose prefilled syringe: 1,000 mg (efgartigimod alfa)/10,000 units (hyaluronidase)/5 mL

VII. References

1. Vyvgart Prescribing Information. Boston, MA: argenx US, Inc.; May 2026. Available at: https://argenx.com/product/vyvgart-prescribing-information.pdf. Accessed June 1, 2026.
2. Vyvgart Hytrulo Prescribing Information. Boston, MA: argenx US, Inc.; May 2026. Available at: https://www.argenx.com/product/vyvgart-hytrulo-prescribing-information.pdf. Accessed June 1, 2026.
3. Howard JF, 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. Lancet Neurology July 2021;20(7):526-36.
4. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. Neurology 2016;87:419-425.
5. Narayanaswami P, Sanders DB, Wolfe G, et al. International consensus guidance for management of myasthenia gravis 2020 update. Neurology 2021;96:114-22.
6. Muppidi S, Silvestri N, Tan R, et al. The evolution of Myasthenia Gravis-Activities of Daily Living (MG-ADL) scale utilization to measure myasthenia gravis symptoms and treatment response (1817). Neurology Apr 2021;96(15 Suppl):1817.
7. Allen JA, Lin J, Basta I, et al. Safety, tolerability, and efficacy of subcutaneous efgartigimod in patients with chronic inflammatory demyelinating polyradiculoneuropathy (ADHERE): a multicentre, randomised-withdrawal, double-blind, placebo-controlled, phase 2 trial. Lancet Neurol. 2024;23(10):1013-1024.
8. Joint Task Force of the EFNS and the PNS. 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. European Journal of Neurology. 2010;17: 356-363.
9. Van den Bergh PYK, van Doorn PA, Hadden RDM, et al. European Academy of Neurology/Peripheral Nerve Society (EAN/PNS) guideline on diagnosis and treatment of chronic inflammatory demyelinating polyradiculoneuropathy: Report of a joint Task Force-Second revision [published correction appears in Eur J Neurol. 2022 Apr;29(4):1288.
10. Bus SR, de Haan RJ, Vermeulen M, van Schaik IN, Eftimov F. Intravenous immunoglobulin for chronic inflammatory demyelinating polyradiculoneuropathy. Cochrane Database Syst Rev. 2024;2(2):CD001797.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9332	Injection, efgartigimod alfa-fcab, 2 mg
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Drug is now FDA approved – criteria updated per FDA labeling: revised requirement for a prior trial of two non-steroidal immunosuppressant therapies to a trial of at least one; added requirement for documentation of member's current weight for dose calculation purposes; references reviewed and updated.	01.04.22	02.22
Added HCPCS code [J9332].	06.30.22	
Updated requirement for no concurrent use to include Ultomiris.	08.09.22	
Added to continuation of therapy requirement for no concurrent use with Soliris or Ultomiris. Template changes applied to other diagnoses/indications and continued therapy section.	08.23.22	11.22
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.22.22	02.23
RT4: Vyvgart Hytrulo added to policy.	06.27.23	
Added HCPCS code [J9334]	10.27.23	
1Q 2024 annual review: no significant changes; references reviewed and updated.	11.29.23	02.24
RT4: added new indication of CIDP for Vyvgart Hytrulo; updated Commercial approval durations from 6/12 months to "6 months or to the member's renewal date, whichever is longer" since this is an injectable agent.	08.27.24	11.24
1Q 2025 annual review: for gMG, added exclusion for concurrent therapy with Bkemv, Epysqli, Zilbrysq, and an FcRn antagonist; for CIDP, added exclusion for concurrent therapy with a complement inhibitor or FcRn antagonist; references reviewed and updated.	11.20.24	02.25
RT4: updated to include new Vyvgart Hytrulo prefilled syringe formulation.	04.23.25	
1Q 2026 annual review: for gMG, clarified that immunosuppressive therapy should be non-steroidal; for CIDP, revised "failure" to "insufficient response" for immune globulin therapy; for continued criteria, clarified that gMG response criterion for 2-point reduction can also be greater than 2 points; for concurrent therapy exclusions agents, added Imaavy; for	10.23.25	02.26

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Medicaid/HIM lines of business, revised approval durations to 12 months; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.		
RT4: updated gMG indication for expansion to all serotypes of gMG and added additional serotype criteria options; added qualifier of anti-AChR antibody-positive gMG for required failure of a cholinesterase inhibitor; for concurrent therapy exclusions for gMG, added Uplizna.	06.01.26	
For CIDP, added ≥ 3 months duration to immune globulin therapy criterion to ensure adequate trial prior to advancing treatment; added ICHRA line of business.	06.02.26	08.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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