Field Name	Field Description
Prior Authorization Group Description	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Agents
Drugs	Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA-approved labeling
Prescriber Restrictions	Prescriber must be a neurologist or neuromuscular specialist.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 3 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria Date: 11/2024	**Drug is being requested through the member's medical benefit** Initial Authorization: • Diagnosis of CIDP confirmed by electrodiagnostic test results (e.g. electromyography or nerve conduction studies) • Patient has progressive or relapsing/remitting disease course for ≥2 months • Patient has an inadequate response, significant intolerance, or contraindication to intravenous immunoglobulin (IVIG) or subcutaneous immunoglobulin (SCIG) • Medication is prescribed at an FDA approved dose Re-Authorization: • Documentation or provider attestation of significant clinical improvement in neurologic symptoms or stabilization of disease • Medication is prescribed at an FDA approved dose If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.