Field Name	Field Description
Prior Authorization Group Description	**Vyvgart**
Drugs	**Vyvgart (efgartigimod)**
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	**≥ 18 years**
Prescriber Restrictions	**Prescribed by or in consultation with a neurologist or rheumatologist**
Coverage Duration	**If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months. If the conditions are not met, the request will be sent to a Medical Director/clinical reviewer for medical necessity review.**
Other Criteria Revision/Review Date: 05/2022	****Drug is being requested through the member's medical benefit**** **Initial Authorization:** • **Diagnosis of generalized myasthenia gravis (gMG)** • **Patient has a positive serological test for anti-AChR antibodies** • **Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II, III or IV** • **Patient has an MG-Activities of Daily Living (MG-ADL) score ≥5** • **Patient has tried and failed, or has contraindication, to 2 or more conventional therapies (i.e. acetylcholinesterase inhibitors, corticosteroids, non-steroidal immunosuppressive therapies)** • **Medication is prescribed at an FDA approved dose** **Re-Authorization:** • **Patient has improved signs and symptoms of MG and/or at least a 2-point improvement in MG-ADL score from pre-treatment baseline** • **Medication is prescribed at an FDA approved dose**

	<u>If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.</u>