Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION AND STEP THERAPY POLICY AND CRITERIA ORPTCOTH044.1024	**MISCELLANEOUS PRODUCTS** **FcRn ANTAGONISTS** See Table 1 for medications covered by policy
Effective Date: 1/1/2025	**Review/Revised Date**: 08/22, 08/23, 05/24, 08/24 (MTW, TVNT)
Original Effective Date: 06/22	**P&T Committee Meeting Date**: 04/22, 10/22, 10/23, 04/24, 10/24
Approved by: Oregon Region Pharmacy and Therapeutics Committee	

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Medicare Part B

POLICY CRITERIA:

COVERED USES:
All Food and Drug Administration (FDA)-Approved Indications

REQUIRED MEDICAL INFORMATION:
For initiation of therapy (new starts), must meet all the indication-specific criteria below:
Generalized Myasthenia Gravis (gMG):
1. Anti-acetylcholine receptor (anti-AChR) antibody positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody positive (Rystiggo® only)
2. One of the following:
    a. For Vyvgart®/Vyvgart Hytrulo®:
        i. Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV
        ii. Myasthenia Gravis - Activities of Daily Living (MG-ADL) total score of five or greater
    b. For Rystiggo®:
        i. Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IVa
        ii. Myasthenia Gravis - Activities of Daily Living (MG-ADL) total score of three or greater (with 3 or greater points from non-ocular symptoms)
3. Failure with treatment of one of the following over the course of at least 12 months, unless intolerance or contraindication to all therapies:

   a. At least TWO immunosuppressive agents (such as azathioprine, methotrexate, cyclosporine, mycophenolate, corticosteroids, tacrolimus, cyclophosphamide, or rituximab)
   b. ONE immunosuppressive therapy and required at least four infusions/year of either intravenous immunoglobulin (IVIG), or plasmapheresis/plasma exchange (PLEX)
4. Dose and frequency are in accordance with FDA-approved labeling

Chronic inflammatory demyelinating polyneuropathy (CIDP):
1. Documentation of current active disease, defined by a CIDP Disease Activity Status (CDAS) of at least 2 (see Appendix 2)
2. Documentation of Inflammatory Neuropathy Cause and Treatment (INCAT) Disability Score of at least 3, or a score of 2 of the legs (see Appendix 3)
3. Documentation of inadequate response to treatment with one of the following, unless both are not tolerated or contraindicated
   a. Systemic corticosteroids
   b. Immune gamma globulin therapy

For patients established on therapy (within the previous year), must meet all the indication-specific criteria below
Generalized Myasthenia Gravis (gMG):
1. Documentation of improvement in Myasthenia Gravis - Activities of Daily (MG-ADL) by at least two points from baseline (for initial reauthorization) or sustained improvement in Myasthenia Gravis - Activities of Daily (MG-ADL) (subsequent reauthorizations)
2. Dose and frequency are in accordance with FDA-approved labeling

Chronic inflammatory demyelinating polyneuropathy (CIDP):
1. Documented positive response to therapy

EXCLUSION CRITERIA: For Generalized Myasthenia Gravis (gMG): Use in combination with other immunomodulatory biologic therapies for myasthenia gravis, such as rituximab, eculizumab (Soliris®), ravulizumab (Ultomiris®), efgartigimod (Vyvgart®/Vyvgart Hytrulo®), rozanolixizumab (Rystiggo®), zilucoplan (Zilbrysq®)

AGE RESTRICTIONS:
May be approved for patients aged 18 years and older

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a neurologist or rheumatologist

COVERAGE DURATION:

Initial authorization will be approved for six months. Reauthorization will be approved for one year.

Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.

Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

INTRODUCTION:

Efgartigimod alfa (Vyvgart®) is approved for the treatment of generalized myasthenia gravis. It is a human immunoglobulin G1 (IgG1) antibody fragment that binds the neonatal Fc receptor (FcRn), resulting in the reduction of circulating IgG and abnormal AChR antibodies. Vyvgart Hytrulo® is approved for the treatment of generalized myasthenia gravis and chronic inflammatory demyelinating polyneuropathy (CIDP). It is a combination of efgartigimod alfa and recombinant human hyaluronidase PH20 (rHuPH20), which is a drug delivery technology that enhances drug delivery in a subcutaneous form.

Rozanolixizumab-noli (Rystiggo®) is a humanized IgG4 monoclonal antibody that binds to the neonatal Fc receptor (FcRn), resulting in the reduction of circulating IgG.

FDA APPROVED INDICATIONS:

Efgartigimod alfa (Vyvgart®): treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

Efgartigimod alfa/hyaluronidase (Vyvgart Hutrulo®):

- Treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive
- Treatment of chronic inflammatory demyelinating polyneuropathy (CIDP).

Rozanolixizumab-noli (Rystiggo®): treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

PHARMACY PRIOR AUTHORIZATION AND STEP THERAPY POLICY AND CRITERIA ORPTCOTH044	MISCELLANEOUS PRODUCTS FcRn ANTAGONISTS See Table 1 for medications covered by policy

POSITION STATEMENT:

Generalized Myasthenia gravis (gMG)

Generalized Myasthenia gravis (gMG) is an autoimmune disorder of neuromuscular transmission. It is characterized by muscle weakness including ocular motor disturbances, oropharyngeal, respiratory, and limb muscle weakness. Symptoms can fluctuate and can become progressively severe. This disorder occurs when proteins in the postsynaptic membrane of the neuromuscular junction (acetylcholine receptors and/or receptor-associated proteins) are attacked by antibody-mediated T-cells.

The diagnosis of myasthenia gravis can be established by clinical and serologic testing. For most patients with a suspected diagnosis of MG, the diagnosis may be confirmed through the presence of autoantibodies against either the acetylcholine receptor (AChR) or another muscle receptor-associated protein, such as muscle-specific tyrosine kinase (MuSK) or low-density lipoprotein receptor-related protein 4 (LRP4). It is estimated that approximately 85% of patients diagnosed with gMG have AChR antibodies, 8% have MuSK antibodies, 1% have LRP4 antibodies, and 6% are seronegative and diagnosis is confirmed using electrodiagnostic testing that shows evidence of impaired signal transmission at the neuromuscular junction.

The myasthenia gravis activities of daily living (MG-ADL) is a categorical scale that assesses the impact on daily function of 8 signs or symptoms that are typically affected in gMG. A 2-point improvement in the MG-ADL indicates clinical improvement.[2-4]

The Medical Scientific Advisory Board (MSAB) of the Myasthenia Gravis Foundation of America (MGFA) developed the MGFA Clinical Classification, which divides MG into five main classes. This classification system is used to evaluate the severity of disease and is commonly used in clinical trial inclusion criteria. See Appendix 1 for more information.[5]

There is no cure for gMG, but rather treatment aims to control symptoms. Per the American Academy of Neurology 2016 guidelines (and 2020 update), the following treatments are recommended for symptomatic and immunosuppressive (IS) treatment of MG:

- Pyridostigmine should be part of the initial treatment in most patients
- Corticosteroids or IS therapy should be used in all patients with MG who have not met treatment goals after an adequate trial of pyridostigmine. A nonsteroidal IS agent should be used alone when corticosteroids are contraindicated or refused.

    - Nonsteroidal IS agents that can be used in MG include azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, and tacrolimus. These therapies can often take several months to show a benefit, and bridging therapies are often required.
    - Corticosteroids should be used as initial IS agent in patients with ocular MG
- Patients with refractory MG should be referred to a physician or a center with expertise in management of MG. In addition to the previously mentioned IS agents, the following therapies may also be used in refractory MG: IVIG, plasma exchange, cyclophosphamide, rituximab
- In non-thymomatous AChR-Ab gMG, thymectomy may be considered early in disease to potentially avoid or minimize the dose or duration of immunotherapy. This procedure should be strongly considered for patients with AChR-Ab+ generalized MG if they fail to respond to an initial adequate trial of immunotherapy or have intolerable side effects.
- Eculizumab (Soliris®) should be considered for severe, refractory, AChR-Ab+ gMG.
- Rituximab should be considered early for patients with MuSK Ab+ gMG with therapeutic failure to immunotherapy[3,4]

Chronic inflammatory demyelinating polyneuropathy (CIDP)
Chronic inflammatory demyelinating polyneuropathy (CIDP) is an autoimmune disorder of the peripheral nervous system. It is characterized by symmetrical limb motor and sensory dysfunction that becomes progressively severe over at least 8 weeks. Variants include focal, multifocal, distal, motor, or sensory. The European Academy of Neurology/Peripheral Neve Society (EFNS/PNS) joint Task Force recommends using electrodiagnosis, response to treatment, ultrasound, monoclonal gammopathy testing, and antibody testing as supportive criteria for a CIDP diagnosis. CSF analysis or nerve biopsy can also be used to diagnose CIDP in specific situations.

Per the EFNS/PNS 2010 guidelines and 2021 update, the following treatments are recommended for CIDP:

- Corticosteroids and IV Immunoglobulin (IVIg) should be first-line treatment options, with IVIg as the first choice for motor CIDP.
- Plasma exchange should be the third treatment option.
- Neuropathic pain should be treated according to guidelines.[6]

Efficacy and safety of efgartimod:
Vyvgart® (efgartigimod alfa) and Vyvgart Hytrulo® are indicated for the treatment of refractory generalized myasthenia gravis in adults who are anti acetylcholine

receptor antibody positive (AChR+). Vyvgart Hytrulo® is also indicated for chronic inflammatory demyelinating polyneuropathy. These therapies are new and not listed in the most recent guidelines but for myasthenia gravis are typically considered in patients who fail or are unable to tolerate corticosteroids or immunosuppressants; they may also be used as a bridge therapy to slower-acting agents.

- Approval of Vyvgart® was based on a phase 3, randomized, double-blind, placebo-controlled trial (NCT036695889, ADAPT trial). The primary endpoint was a comparison of the percentage of MG-ADL responders during the first treatment cycle between treatment groups in the AChR-Ab positive population.
- Inclusion criteria: Age greater than 18 years, all serotypes, regardless of Ab status and including MuSK, LRP4, and AChR-Ab- in addition to AChR-Ab+, MGFA Class II-IV gMG, MG-ADL score ≥5, receiving a stable dose of ≥1 of the following gMG treatments prior to randomization: acetylcholinesterase inhibitors (no dose change for 2 weeks prior to screening), steroids (at least 3 months of treatment, no dose change for one month) or NSIST (at least 6 months of treatment, no dose change for three months).
- MGFA Class I and V patients were excluded from this clinical trial.
- Moderate quality of evidence that efgartigimod results in a statistically significant difference in the MG-ADL (Myasthenia Gravis-Specific Activities of Daily Living) responder rate during the first treatment cycle in patients with gMG compared to placebo
- Although AChR antibody–negative patients were included in the ADAPT trial, they were not included in the study's final analysis. The FDA-approved labeling of Vyvgart® excludes use in the AChR antibody–negative population. In the ADAPT trial, 68% of acetylcholine receptor antibody-negative efgartigimod-treated patients had a response, similar to that in acetylcholine receptor antibody-positive patients, but there was an unexpectedly high response rate in the placebo group. A post-hoc analysis of acetylcholine receptor antibody-negative patients who were both MG-ADL and QMG responders in cycle 1 showed a treatment effect, suggesting efgartigimod might be effective in this patient population.[7]
- Approval of Vyvgart Hytrulo® for gMG was based on the ADAPT and ADAPTsc trial
- Study design: multicenter, randomized, open-label, parallel-group bridging study to the ADAPT trial that goy Vyvgart® its FDA approval
- Patients were randomized to receive Vyvgart® or Vyvgart Hytrulo® for one treatment cycle [1]
- Vyvgart Hytrulo® met the primary endpoint of noninferiority to Vyvgart®[1]
- Approval of Vyvgart Hytrulo® for CIDP was based on the ADHERE trial
    - Study design: multicenter, randomized-withdrawal, double-blind, placebo-controlled, phase 2 trial

- Eligible participants met the following inclusion criteria at screening:
  - A CIDP Disease Activity Status (CDAS) of at least 2, AND
  - An Inflammatory Neuropathy Cause and Treatment (INCAT) Disability Score of at least 3, or a score of 2 of the legs.
  - Refer to Appendices 2 and 3 for more information.
- Patients were randomized to receive 1000 mg subcutaneous efgartigimod PH20 weekly versus placebo for a maximum of 48 weeks, after an open-label phase where all patients received 1000 mg subcutaneous efgartigimod PH20 weekly for a maximum of 12 weeks.
- Subcutaneous efgartigimod PH20 showed statistically significant reduction in relapse risk versus placebo.[8]

- Safety: [1] Both Vyvgart® and Vyvgart Hytrulo® have similar safety profile
  - Warnings and Precautions: Increased risk of infections, hypersensitivity reactions
  - The most common adverse reactions were respiratory tract infection, headache, and urinary tract infection
- Dosing:[1]
  - Vyvgart® should be administered via intravenous infusion by a healthcare professional.
    - The recommended dosage is 10 mg/kg administered as an intravenous infusion over one hour once weekly for four weeks. In patients weighing 120 kg or more, the recommended dose is 1200 mg (three vials) per infusion.
  - Vyvgart Hytrulo® is administered as a subcutaneous injection over 30-90 seconds by a healthcare professional
    - The recommended dosage for both gMG and CIDP is a fixed dose of 1008 mg once weekly
  - For gMG, each cycle for both agents consists of once weekly doses for four (4) weeks. Administer subsequent treatment cycles 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.

Cost Effectiveness of efgartimod[9]:
Given the information available regarding short-term benefits, with uncertainties about dosing, long-term benefits, and long-term safety, ICER concluded there is "moderate certainty of a comparable, small, or substantial net health benefit of efgartigimod added to conventional therapy with high certainty of at least comparable net health benefit (C++) in adults with gMG positive for anti-AChR antibodies".

- With sparse and uncertain clinical and statistical significance of the evidence of efgartigimod in adults with gMG negative for anti-AChR antibodies, ICER

concluded that the evidence was insufficient to determine the net health benefit of adding efgartigimod to conventional therapy versus conventional therapy alone in this population. In addition, there is insufficient evidence to determine the net health benefits of rituximab and IVIG from placebo, eculizumab, and efgartigimod.

Icer evaluated the cost effectiveness of efgartigimod added to conventional therapy versus conventional therapy alone in the patients with gMG, including those with or without anti-AChR-antibodies. Using a placeholder price of $418,400, the incremental cost per QALY and incremental cost per evLYG were estimated to be $2,076,000. From the cost-effectiveness base case, ICER estimated the health benefit price benchmark (HBPB) for efgartigimod. The HBPB range was estimated to be $18,300 to $28,400 (discounts not presented due to placeholder price).

Annual Health Benefit Price Benchmarks for Efgartigimod

	Annual FSS	Annual Price at $100,000 Threshold	Annual Price at $150,000 Threshold	Discount from FSS to Reach Threshold Prices
QALYs Gained	NA	$18,300	$28,400	NA
evLYG	NA	$18,300	$28,400	NA

evLYG: equal value life year gained, QALY: quality-adjusted life year, FSS: Federal Supply Schedule, NA: not applicable
*There were no differences in survival. Cost per evLYG is equal to the cost per QALY gained.
**Efgartigimod evaluated using an annual placeholder price of $418,400

Benefits not included in the economic model include potential to improve childbearing age career opportunities for women who are diagnosed early in their lives. MG is serious and lifelong with life-threatening manifestations, and most patients do not achieve treatment goals with conventional therapy. Efgartigimod improves function and quality of life for patients with gMG, however has an incremental cost-effectiveness ration well above typical willingness-to-pay-thresholds.

Efficacy and safety of rozanolixizumab[10]:

- The approval for Rystiggo was based on one randomized, double-blind, placebo-controlled, parallel-group, two-stage adaptive, phase 3 clinical trial (MycarinG [NCT03971422, PubMed ID #37059507]. The study consisted of a 4-week screening period and 6-week treatment period, followed by 8 weeks of observation. Participants (n=200) were all ≥18 years old with a diagnosis of gMG, MGFA class II–IVa, presence of AChR or MuSK autoantibodies, MG-ADL ≥ 3 (for non-ocular symptoms), on a stable dose of MG therapy prior to screening that included AChE inhibitors (stable dose not required), oral corticosteroids (stable

for 4 weeks before baseline), azathioprine, cyclosporine, methotrexate, mycophenolate mofetil, and tacrolimus (all received for the previous 6 months and on a stable dose 2 months before baseline), in combination or monotherapy. Individuals were excluded if they had severe oropharyngeal or respiratory weakness or clinically relevant active infection, recent serious infection.
    - Prohibited concomitant medications: intravenous immunoglobulin or plasma exchange (other than when used as rescue therapy), biological agents (including rituximab and eculizumab), cyclophosphamide, pimecrolimus, immunoadsorption, and vinca alkaloids
    - Baseline demographics: median MG-ADL total score was 8 and median quantitative myasthenia gravis (QMG) total score was 15. 89.5% were positive for AChR antibodies; 10.5% were positive for anti-MuSK antibodies. At baseline, more than 83% of patients received AChE inhibitors, more than 56% received steroids, and 50% received NSISTs at stable doses
- All participants were randomly assigned to rozanolixizumab 7 mg/kg, rozanolixizumab 10 mg/kg, or placebo, once a week for 6 weeks. Randomization was stratified by presence of AChR or MuSK autoantibodies. The primary endpoint was the change from baseline to day 43 in MG-ADL. Key secondary endpoints included the change from baseline to day 43 in QMG and MG-ADL response (based on the established clinically meaningful improvement on an individual patient level of ≥2 points).
- Efficacy:

Efficacy Endpoints	**Rozanolixizumab 7 mg/kg n = 66**	**Rozanolixizumab 10 mg/kg n = 67**	**Placebo n = 67**
MG-ADL Total Score			
Least-squares (LS) Mean (Standard of Error [SE])	−3.37 (0.49)	-3.4 (0.49)	-0.78 (0.49)
Difference from placebo (95% CI)	-2.59 (-4.09, -1.25)	-2.62 (-3.99, -1.16)	-
P-value	<0.001	<0.001	-
QMG Total Score			
LS Mean (SE)	−5.40 (0.7)	−6.67 (0.7)	−1.92 (0.7)
Difference from placebo (95% CI)	−3.48 (−5.61, −1.58)	−4.76 (−6.82, −2.86)	-
P-value	<0.001	<0.001	-
MG-ADL responders			
Measure*	46/64 (72%)	43/62 (69%	20/64 (31%)

*Observed values; this outcome was not included in the hierarchical testing procedure

    - Reductions from baseline to day 43 in MG-ADL scores were observed in patients with AChR autoantibody-positive gMG (rozanolixizumab 7 mg/kg

least-squares mean –3.03 [SE 0.89]; rozanolixizumab 10 mg/kg –3.36 [0.87]; placebo –1.10 [0.87]; least-squares mean difference from placebo −1.94 [97.5% CI −3.06 to −0.81] and −2.26 [−3.39 to −1.13] in the rozanolixizumab 7 mg/kg and 10 mg/kg groups, respectively). For patients with MuSK autoantibody-positive gMG, least-squares mean reductions were –7.28 [SE 1.94] in the rozanolixizumab 7 mg/kg group, –4.16 [1.78] in the rozanolixizumab 10 mg/kg group, and 2.28 [1.95] in the placebo group (least-squares mean difference from placebo for rozanolixizumab 7 mg/kg −9.56 [97.5% CI −15.25 to −3.87]; −6.45 [−11.03 to –1.86] for the rozanolixizumab 10 mg/kg group).
    - Both rozanolixizumab groups showed statistically significant improvements compared with placebo for change from baseline to day 43 in MGC scores, Myasthenia Gravis Symptoms PRO scales were also significantly improved.
    - Improvements from baseline in MG-ADL, MGC, QMG, and Myasthenia Gravis Symptoms PRO scores were seen as early as day 8 and throughout the treatment period, before returning towards baseline levels by day 99
- Safety:
    - Side effects experienced by ≥10% of patients in treatment group (n = 133): headache (44%), infections (23%), diarrhea (20%), pyrexia (17%), hypersensitivity reactions (11%), and nausea (10%).

REFERENCE/RESOURCES:

1. Relevant package inserts
2. Myasthenia Gravis Foundation of America. Clinical overview of MG. Available at https://myasthenia.org/Professionals/Clinical-Overview-of-MG (Accessed May 15, 2024).
3. Narayanaswami P, Sanders DB, Wolfe G, et al. International Consensus Guidance for Management of Myasthenia Gravis 2020 Update. *Neurology*. 2021; 96(3):114-122.
4. Sanders DB, Wolfe GI, Benatar M, Evoli A, Gilhus NE, Illa I, Kuntz N, Massey JM, Melms A, Murai H, Nicolle M, Palace J, Richman DP, Verschuuren J, Narayanaswami P. International consensus guidance for management of myasthenia gravis: Executive summary. *Neurology*. 2016 Jul 26;87(4):419-25. doi: 10.1212/WNL.0000000000002790.
5. Jaretzki A, 3rd, Barohn RJ, Ernstoff RM, et al. Myasthenia gravis: recommendations for clinical research standards. Task Force of the Medical Scientific Advisory Board of the Myasthenia Gravis Foundation of America. Neurology. 2000;55(1):16-23.
6. Van den Bergh PYK, van Doorn PA, Hadden RDM, et al. European Academy of Neurology/Peripheral Nerve Society guideline on diagnosis and treatment

of chronic inflammatory demyelinating polyradiculoneuropathy: Report of a joint Task Force—Second revision. *Eur J Neurol*. 2021 July 20;28(11):3556-3583.

7. Howard JF Jr, et al. Safety, efficacy, and tolerability of efgartigimod in patients with generalised myasthenia gravis (ADAPT): a multicentre, randomised, placebo-controlled, phase 3 trial [published correction appears in *Lancet Neurol*. 2021 Aug;20(8):e5]. *Lancet Neurol*. 2021;20(7):526–536. doi:10.1016/S1474-4422(21)00159-9.
8. 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, randomized-withdrawal, double-blind, placebo-controlled, phase 2 trial. *Lancet Neurol*. 2024;23(10):1013-1024. doi: 10.1016/S1474-4422(24)00309-0
9. Tice JA, Touchette DR, Nikitin D, Campbell JD, Lien P-W, Moradi A, Rind DM, Pearson SD, Agboola F. Eculizumab and Efgartigimod for the Treatment of Myasthenia Gravis: Effectiveness and Value; Final Report. Institute for Clinical and Economic Review, October 20, 2021. https://icer.org/wp-content/uploads/2021/03/ICER_Myasthenia-Gravis_Final-Report_102021-1.pdf
10. Bril V, et al. Safety and efficacy of rozanolixizumab in patients with generalised myasthenia gravis (MycarinG): a randomised, double-blind, placebo-controlled, adaptive phase 3 study. Lancet Neurol. 2023;22(5):383–394. Accessed August 23, 2023. doi:10.1016/S1474-4422(23)00077-7
11. Gorson KC, van Schaik IN, Merkies ISJ, et al. Chronic inflammatory demyelinating polyneuropathy disease activity status: recommendations for clinical research standards and use in clinical practice. *J Peripher Nerv Syst* 2010; 15(4):326-333. doi:10.1111/j.1529-8027.2010.00284.x
12. Hughes R, Bensa S, Willison H, et al. Randomized controlled trial of intravenous immunoglobulin versus oral prednisolone in chronic inflammatory demyelinating polyradiculoneuropathy. *Ann Neurol* 2001; 50(2): 195-201. doi:10.1002/ana.1088

Appendix 1

Myasthenia Gravis Foundation of America (MGFA) clinical classification of MG[9]	
Class (I-V)	**Clinical features**
Class I	Any ocular muscle weakness. May have weak eye closure. All other muscle strength is normal.
Class II	Mild weakness affecting non-ocular muscles May also have any ocular weakness
IIa	Predominantly affecting limb or axial muscles or both May also have oropharyngeal muscle weakness (less than limb/axial)

	vs
IIb	Predominantly affecting oropharyngeal or respiratory muscles or both May also have limb or axial or both muscle involvement (less or equal to oropharyngeal/respiratory)
Class III	Moderate weakness affecting non-ocular muscles May also have any ocular weakness
IIIa	Predominantly affecting limb or axial muscles or both May also have oropharyngeal muscle weakness (less than limb/axial)
	vs
IIIb	Predominantly affecting oropharyngeal or respiratory muscles or both May also have limb or axial or both muscle involvement (less or equal to oropharyngeal/respiratory)
Class IV	Severe weakness affecting non-ocular muscles May also have any ocular weakness
IVa	Predominantly affecting limb or axial muscles or both May also have oropharyngeal muscle weakness (less than limb/axial)
	vs
IVb*	Predominantly affecting oropharyngeal or respiratory muscles or both May also have limb or axial or both muscle involvement (less or equal to oropharyngeal/respiratory)
Class V	Defined by intubation with or without mechanical ventilation (except when this is employed during routine post-op management)

Note: use of a feeding tube without intubation places a patient in class IVb

Appendix 2

CIPD Disease Activity Status (CDAS) classification[11]
1. Cure: ≥5 years off treatment A. Normal examination B. Abnormal examination, stable/improving
2. Remission: <5 years off treatment A. Normal examination B. Abnormal examination, stable/improving
3. Stable active disease: ≥1 year, on treatment A. Normal examination B. Abnormal examination, stable/improving
4. Improvement: ≥3 months <1 year, on treatment A. Normal examination B. Abnormal examination, stable/improving

5. Unstable active disease: abnormal examination with progressive or relapsing course
   A. Treatment naïve or <3 months
   B. Off treatment
   C. On treatment

Appendix 3

Inflammatory Neuropathy Cause and Treatment (INCAT) Disability Scale[12]	
Arm disability	
0	No upper limb problems
1	Symptoms, in one or both arms, not affecting the ability to perform any of the following functions: • doing all zips and buttons; • washing or brushing hair; • using a knife and fork together; and • handling small coins
2	Symptoms, in one arm or both arms, affecting but not preventing any of the above-mentioned functions
3	Symptoms, in one arm or both arms, preventing one or two of the above-mentioned functions
4	Symptoms, in one arm or both arms, preventing three or all of the functions listed, but some purposeful movements still possible
5	Inability to use either arm for any purposeful movement
Leg disability	
0	Walking not affected
1	Walking affected, but walks independently outdoors
2	Usually uses unilateral support (stick, single crutch, one arm) to walk outdoors
3	Usually uses bilateral support (sticks, crutches, frame, two arms) to walk outdoors
4	Usually uses wheelchair to travel outdoors, but able to stand and walk a few steps with help
5	Restricted to wheelchair, unable to stand and walk a few steps with help
Overall disability = sum of arm and leg disability	

Table 1

Brand Name	Generic Name	HCPCS Code
Rystiggo	rozanolixizumab-noli	J9333
Vyvgart	efgartigimod alfa	J9332
Vyvgart Hytrulo	efgartigimod alfa/ hyaluronidase	J9334