# Clinical Policy: Rozanolixizumab-noli (Rystiggo)

**Reference Number: LA.PHAR.648**
**Effective Date:**
**Last Review Date: 01.04.24**
**Line of Business: Medicaid**

**Coding Implications Revision Log**

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

****Please note: This policy is for medical benefit****

## Description

**Rozanolixizumab-noli (Rystiggo®) is a neonatal Fc receptor blocker.**

## FDA Approved Indication(s)

**Rystiggo is indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.**

## 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 Louisiana Healthcare Connections that Rystiggo is 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) ≥ 3 from non-ocular symptoms at baseline;**
5. **Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IVa;**
6. **Member has positive serologic test for one of the following (a or b):**
   a. **Anti-AChR antibodies;**
   b. **Anti-MuSK antibodies;**
7. **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;**
8. **Failure of a corticosteroid (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;**
9. **Failure of at least one immunosuppressive therapy (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;**

10. **Rystiggo is not prescribed concurrently with Vyvgart®, Vyvgart® Hytrulo, Soliris®, or Ultomiris®;**
11. **Documentation of member's current weight (in kg);**
12. **Dose does not exceed one of the following (a, b, or c) once weekly for the first 6 weeks of every 9-week cycle:**
    a. **Weight < 50 kg and both (i and ii):**
       i. **420 mg;**
       ii. **2 vials;**
    b. **Weight 50 kg to < 100 kg and both (i and ii):**
       i. **560 mg;**
       ii. **2 vials;**
    c. **Weight ≥ 100 kg and both (i and ii):**
       i. **840 mg;**
       ii. **3 vials;**

**Approval duration: 6 months**

B. **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 LA.PMN.255;**
   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 LA.PMN.53.**

II. **Continued Therapy**

A. **Generalized Myasthenia Gravis (must meet all):**
   1. **Member is currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;**
   2. **Member is responding positively to therapy as evidenced by a 2-point reduction in MG-ADL total score from baseline;**
   3. **Rystiggo is not prescribed concurrently with Vyvgart, Vyvgart Hytrulo, Soliris, or Ultomiris;**
   4. **Documentation of member's current weight (in kg);**
   5. **If request is for a dose increase, new dose does not exceed one of the following (a, b, or c) once weekly for the first 6 weeks of every 9-week cycle:**
      a. **Weight < 50 kg and both (i and ii):**
         i. **420 mg;**
         ii. **2 vials;**
      b. **Weight 50 kg to < 100 kg and both (i and ii):**
         i. **560 mg;**
         ii. **2 vials;**
      c. **Weight ≥ 100 kg and both (i and ii):**
         i. **840 mg;**
         ii. **3 vials;**

**Approval duration: 6 months**

**B. 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 LA.PMN.255;**
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 LA.PMN.53.**

**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 –LA.PMN.53 for Medicaid or evidence of coverage documents.**

**IV. Appendices/General Information**

***Appendix A: Abbreviation/Acronym Key***

**AChR: acetylcholine receptor**
**FDA: Food and Drug Administration**
**gMG: generalized myasthenia gravis**
**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 require prior authorization.***

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| **Corticosteroids** | | |
| betamethasone | Oral: 0.6 to 7.2 mg PO per day | 7.2 mg/day |
| dexamethasone | Oral: 0.75 to 9 mg/day PO | 9 mg/day |
| methylprednisolone | Oral: 12 to 20 mg PO per day; increase as needed by 4 mg every 2-3 days until there is marked clinical improvement | 40 mg/day |
| prednisone | Oral: 15 mg/day to 20 mg/day; increase by 5 mg every 2-3 days as needed | 60 mg/day |
| **Cholinesterase Inhibitors** | | |
| pyridostigmine (Mestinon®) | Oral immediate-release: 600 mg daily in divided doses (range, 60-1,500 mg daily in divided doses)<br>Oral sustained release: 180-540 mg QD or BID | Immediate-release: 1,500 mg/day<br>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) | Oral: 375 mg/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | IM or SC: 0.5 mg based on response to therapy | |
| **Nonsteroidal Immunosuppressants** | | |
| 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), Truxima® (rituximab-abbs)*† | 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$^2$ |

***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***
**None reported**

***Appendix D: General Information***
- **The MGFA stratifies patients by the extent and severity of muscle weakness. The classification has some subjectivity in it when it comes to distinguishing mild (Class II) from moderate (Class III) and moderate (Class III) from severe (Class IV). Furthermore, it is insensitive to change from one visit to the next.**
  - **The degree of impairment in Class IVa is predominantly in the limb and/or axial muscles whereas impairment in Class IVb is predominantly in the oropharyngeal and/or respiratory muscles. The clinical classification can be accessed here: https://myasthenia.org/Portals/0/MGFA%20Classification.pdf**
- **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. The scale can be accessed here: https://myasthenia.org/Portals/0/ADL.pdf**

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| gMG | Initial dosage is administered as SC infusion once weekly for 6 weeks based on body weight:<br>• < 50 kg: 420 mg<br>• 50 kg to < 100 kg: 560 mg<br>• ≥ 100 kg: 840 mg<br><br>Subsequent treatment cycles administered based on clinical evaluation; the safety of initiating subsequent cycles sooner than 63 days from the start of the previous treatment cycle has not been established. | 840 mg/week |

## VI. Product Availability

Single-dose vial: 280 mg/2 mL (140 mg/mL)

## VII. References

1. Rystiggo Prescribing Information. Smyrna, GA: UCB; June 2023. Available at: https://www.ucb-usa.com/RYSTIGGO-prescribing-information.pdf. Accessed July 10, 2023.
2. Bril V, Drużdż A, Grosskreutz J, 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.
3. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. Neurology 2016;87:419-425.
4. Narayanaswami P, Sanders DB, Wolfe G, et al. International consensus guidance for management of myasthenia gravis 2020 update. Neurology 2021;96:114-22.

## 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 |
|---|---|
| J3590 | Unclassified biologics |
| C9399 | Unclassified drugs or biologicals |

| Reviews, Revisions, and Approvals | Date | LDH Approval Date |
|---|---|---|
| Converted corporate to local policy. | 01.04.24 | |

## 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. LHCC 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.**

**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 LHCC administrative policies and procedures.**

**This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.**

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