Clinical Policy: Rozanolixizumab-noli (Rystiggo)

Reference Number: LA.PHAR.648
Effective Date: 06.06.24
Last Review Date: 01.15.25
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®/ Bkemv™/Epysqli®, Ultomiris®, or Zilbrysq®;
11. Documentation of member's current weight (in kg);
12. Dose does not exceed both of the following (a and b) once weekly for the first 6 weeks of every 9-week cycle:
    a. One of the following (i, ii, or iii):
        i. Weight < 50 kg: 420 mg;
        ii. Weight 50 kg to < 100 kg: 560 mg;
        iii. Weight ≥ 100 kg: 840 mg;
    b. 1 vial.

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)**:**
    a. 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/Bkemv/Epysqli, Ultomiris, or Zilbrysq;
4. Documentation of member's current weight (in kg);
5. If request is for a dose increase, new dose does not exceed both of the following (a and b) once weekly for the first 6 weeks of every 9-week cycle:
    a. One of the following (i, ii, or iii):
        i. Weight < 50 kg: 420 mg;
        ii. Weight 50 kg to < 100 kg: 560 mg;
        iii. Weight ≥ 100 kg: 840 mg;
    b. 1 vial.

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) 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
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

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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: • < 50 kg: 420 mg • 50 kg to < 100 kg: 560 mg • ≥ 100 kg: 840 mg Subsequent treatment cycles administered based on clinical evaluation; the safety of initiating subsequent	840 mg/week

Indication	Dosing Regimen	Maximum Dose
	cycles sooner than 63 days from the start of the previous treatment cycle has not been established.	

VI. Product Availability

Single-dose vials: 280 mg/2 mL (140 mg/mL), 420 mg/3 mL (140 mg/mL), 560 mg/4 mL (140 mg/mL), 840 mg/6 mL (140 mg/mL)

VII. References

1. Rystiggo Prescribing Information. Smyrna, GA: UCB; June 2024. Available at: https://www.ucb-usa.com/RYSTIGGO-prescribing-information.pdf. Accessed July 25, 2024.
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	06.06.24
Annual review: added new 420 mg/3 mL, 560 mg/4 mL, and 840/6 mL volume formulations and updated all quantity limits to 1 vial; added Bkemv, Epysqli, and Zilbrysq to the list of therapies that Rystiggo should not be prescribed concurrently with; references reviewed and updated.	01.15.25	

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.

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