Effective Date: 08/01/2024
Reviewed: 5/2024, 10/2025

ZILBRYSQ (zilucoplan)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Zilbrysq is indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Generalized myasthenia gravis (gMG)
Authorization of 6 months may be granted for the treatment of generalized myasthenia gravis (gMG) when all of the following criteria are met:

1. Member is ≥ 18 years of age
2. Prescribed by, or in consultation, with a neurologist
3. Documentation with medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of generalized myasthenia gravis (gMG)
4. Documentation that member has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies
5. Documentation that member has Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II to IVb disease
6. Physician has assessed objective signs of neurological weakness and fatigability on a baseline neurological examination (e.g., including, but not limited to, the Quantitative Myasthenia Gravis (QMG) score or the MG-Activities of Daily Living (MG-ADL) score, etc.)
7. Documentation that member has a baseline MG activities of daily living (MG-ADL) total score ≥6
8. Documentation that member meets one of the following:
    a. The patient has tried and had an inadequate response to at least ONE conventional agent used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide)
    b. The patient has an intolerance or hypersensitivity to ONE conventional agent used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide)
    c. The patient has an FDA labeled contraindication to ALL conventional agents used for the treatment of myasthenia gravis (i.e., corticosteroids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide)

   d. The patient required chronic intravenous immunoglobulin (IVIG)
   e. The patient required chronic plasmapheresis/plasma exchange
9. The patient's current medications have been assessed and any medications known to exacerbate myasthenia gravis (e.g., beta blockers, procainamide, quinidine, magnesium, anti-programmed death receptor-1 monoclonal antibodies, hydroxychloroquine, aminoglycosides) have been discontinued **OR** discontinuation of the offending agent is NOT clinically appropriate
10. Documentation that the member has an inadequate response or contraindication to both of the following:
    a. Vyvgart (efgartigimod) or Vyvgart Hytrulo (efgartigimod and hyaluronidase)
    b. Rystiggo (rozanolixizumab) or eculizumab
11. Will not be used in combination with Soliris/Epysqli/Bkemv (eculizumab), Ultomiris (ravulizumab), Rystiggo (rozanolixizumab), Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod and hyaluronidase), or Imaavy (nipocalimab)
12. The dose does not exceed the following based on actual body weight (current weight provided):
    a. Less than 56kg: 16.6mg daily
    b. 56kg to less than 77kg: 23mg daily
    c. 77 kg and above: 32.4mg daily

III. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization when the following criteria are met:

1. The member was previously approved for the requested drug through the plan's Pharmacy Drug Review process (Note: patients not previously approved for the requested agent will require initial evaluation review)
2. Documentation that member demonstrates a positive response to therapy by an improvement (i.e., reduction) of at least 2-points from baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score sustained for at least 4-weeks ***Δ***
3. Zilbrysq continues to be prescribed by, or in consultation with, a neurologist
4. The member will not use the requested agent in combination with Soliris/Epysqli/Bkemv (eculizumab), Ultomiris (ravulizumab), Rystiggo (rozanolixizumab), Vyvgart (efgartigimod), Vyvgart Hytrulo (efgartigimod and hyaluronidase), or Imaavy (nipocalimab)
5. Prescribed dose provided, and in accordance with FDA-approved labeling based on current documented weight

*(**Δ** May substitute an improvement of at least 3-points from baseline in the Quantitative Myasthenia Gravis (QMG) total score sustained for at least 4-weeks, if available)*

IV. QUANTITY LIMIT

Zilbrysq 16.6mg/0.416ml, 23mg/0.574ml, 32.4mg/0.81ml: 1 syringe per day or 28 syringes per 28 days

V. REFERENCES

1. Zilbrysq [package insert]. Smyrna, GA: UCB, Inc.; February 2025.
2. Sanders D, Wolfe G, Benatar M et al. International consensus guidance for management of myasthenia gravis. *Neurology*. 2021; 96 (3) 114-122.
3. Howard JF, et al. Safety and efficacy of zilucoplan in patients with generalised myasthenia gravis (RAISE): a randomised, double-blind, placebo-controlled, phase 3 study. Lancet Neurol. 2023;22(5):395-406.
4. Barnett C, Herbelin L, Dimachkie MM, Barohn RJ. Measuring Clinical Treatment Response in Myasthenia Gravis. Neurol Clin. 2018 May;36(2):339-353.