AETNA BETTER HEALTH®
Coverage Policy/Guideline

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Effective Date:	7/14/2025	Last Review Date:	6/16/2025

Applies to: ☒Illinois ☒New Jersey ☒Maryland ☒Kentucky PRMD ☒Florida Kids ☒Pennsylvania Kids ☒Virginia

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Imaavy under the patient's prescription drug benefit.

Description:

FDA-Approved Indication
Imaavy is indicated for the treatment of generalized myasthenia gravis (gMG) in adult and pediatric patients 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.

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

Applicable Drug List:

Imaavy

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- For initial requests, chart notes, medical records, or claims history documenting:
  - Positive anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody test.
  - Myasthenia Gravis Foundation of America (MGFA) clinical classification.
  - MG activities of daily living score.
  - Previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reasons to avoid therapy.
- For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Exclusions

The requested medication will not be used in combination with another neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart, Vyvgart Hytrulo) or complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq).

Criteria for Initial Approval:

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

- Anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive.
- Myasthenia Gravis Foundation of America (MGFA) clinical classification II to IV.
- MG activities of daily living (MG-ADL) total score of greater than or equal to 5.
- Meets ONE of the following:
  - Member has had an inadequate response or intolerable adverse event to at least two immunosuppressive therapies over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, tacrolimus).
  - Member has had an inadequate response or intolerable adverse event to at least one immunosuppressive therapy and intravenous immunoglobulin (IVIG) over the course of at least 12 months.
  - Member has a documented clinical reason to avoid therapy with immunosuppressive agents and IVIG

Criteria for Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when there is no evidence of unacceptable toxicity or disease progression while on the current regimen and member demonstrates a positive response to therapy (e.g., improvement in MG-ADL score, MG Manual Muscle Test (MMT), MG Composite).

Approval Duration and Quantity Restrictions:

Initial Approval: 6 months

Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Imaavy [package insert]. Horsham, PA: Janssen Biotech, Inc.; May 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. Barnett C, Herbelin L, Dimachkie MM, Barohn RJ. Measuring Clinical Treatment Response in Myasthenia Gravis. Neurol Clin. 2018 May;36(2):339-353.