Mass General Brigham
Health Plan

Zilbrysq (zilucoplan)
Effective 01/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Zilbrysq (zilucoplan) is a complement inhibitor indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

Coverage Guidelines
Authorization may be reviewed for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted for members when ALL the following criteria are met:

1. Member has a diagnosis of generalized myasthenia gravis (gMG)
2. Member is anti-acetylcholine receptor (AChR) antibody positive
3. Member has a Myasthenia Gravis Found of America (MGFA) clinical classification score of II to IV
4. Member has a Myasthenia Gravis Activities of Daily Living (MG-ADL) total score of ≥ 6
5. Member meets TWO of the following:
    a. Member has had an inadequate response or adverse reaction to at least one of the following immunosuppressive therapies:
        i. Azathioprine
        ii. Cyclosporine
        iii. Mycophenolate mofetil
        iv. Tacrolimus
        v. Methotrexate
        vi. Cyclophosphamide
        vii. Rituximab
    b. Member has had an inadequate response or adverse reaction to an acetylcholinesterase inhibitor (e.g., pyridostigmine)

c. Member has had an inadequate response or adverse reaction to immune globulin (IVIG or SCIG)
d. Member has had an inadequate response or adverse reaction to ONE of the following:
    i. Soliris
    ii. Ultomiris

Continuation of Therapy

Reauthorization requests will be approved when the following criteria are met:

1. Member demonstrates a positive response to therapy (e.g., improvement in MG-ADL score, changes compared to baseline in Quantitative Myasthenia Gravis (QMG) total score)

Limitations

1. Initial requests will be approved for 6 months
2. Reauthorization requests will be approved for 12 months

References

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Review History
10/09/2025 – Reviewed at October P&T. Effective 1/1/2025.