

Zilbrysq (zilucoplan)
Effective 01/01/2025

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 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.

