Mass General Brigham
Health Plan

Complement Inhibitors
Imaavy (nipocalimab-aahu)
Effective 11/17/2025

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
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		
Notes	Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
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.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with 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:

Generalized Myasthenia Gravis (MG), AChR-antibody+
1. Diagnosis of generalized MG
2. Member is ≥ 12 years of age
3. Member is AChR antibody positive
4. Prescriber is a neurologist or consult notes from specialist are provided
5. Inadequate response, adverse reaction, or contraindication to pyridostigmine
6. ONE of the following:
    a. BOTH of the following:
        i. Member has severe disease requiring faster onset medication
        ii. Inadequate response, adverse reaction or contraindication to IVIG or plasmapheresis with glucocorticoids
    b. Inadequate response or adverse reaction to TWO or contraindication to ALL of the following immunosuppressant trials
        i. Azathioprine
        ii. Cyclosporine

iii. Glucocorticoids (e.g., prednisone)
iv. Mycophenolate
v. Tacrolimus

7. Inadequate response, adverse reaction, or contraindication to ONE of the following:
    a. Vyvgart
    b. Vyvgart Hytrulo
8. Appropriate dosing

Generalized Myasthenia Gravis (MG), MuSK-antibody+

1. Diagnosis of MG
2. Member is ≥ 12 years of age
3. Member MuSK antibody positive
4. Prescriber is a neurologist or consult notes from specialist are provided
5. Inadequate response, adverse reaction, or contraindication to pyridostigmine
6. ONE of the following:
    a. BOTH of the following:
        i. Member has severe disease requiring faster onset medication
        ii. Inadequate response, adverse reaction or contraindication to IVIG or plasmapheresis with glucocorticoids
    b. Inadequate response or adverse reaction to TWO or contraindication to ALL of the following immunosuppressant trials:
        i. Azathioprine
        ii. Cyclosporine
        iii. Glucocorticoids (e.g., prednisone)
        iv. Rituximab
        v. Mycophenolate
        vi. Tacrolimus
7. Appropriate dosing

Continuation of Therapy

Prescriber must provide documentation of positive response to therapy.

Limitations

1. Initial approvals will be granted for 6 months.
2. Reauthorizations will be granted for 12 months.

References

1. Imaavy [package insert] Horsham (PA): Janssen Biotech, Inc ; 2025 Apr

Review History

10/8/25 – Created for P&T. New drug, Imaavy, will be managed on medical benefit with PA. As part of the HOPA implementation, criteria is aligned. Effective 11/17/25