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# Ublituximab

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## Related Coverage Resources

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## Overview

This policy supports medical necessity review for ublituximab (Briumvi™).

Additional criteria that support the review for medical necessity exceptions of non-covered products are located in the Non-Covered Product Table by the respective plan type and drug list where applicable.

Receipt of sample product does not satisfy any criteria requirements for coverage.

## Medical Necessity Criteria

**Ublituximab (Briumvi) is considered medically necessary when the following is met:**

**Multiple Sclerosis.** Individual meets **ALL** of the following criteria:
1. 18 years of age or older
2. Documented diagnosis of **ONE** of the following relapsing forms of Multiple Sclerosis:

a. Active Secondary Progressive Multiple Sclerosis (SPMS) (for example, SPMS with a documented relapse)
b. Clinically Isolated Syndrome (CIS)
c. Relapsing-Remitting Multiple Sclerosis (RRMS)

3. Preferred Product Step Therapy Criteria is met, refer to below table(s)

**Employer Group Drug Lists:**

| Product | Criteria |
|---|---|
| **Briumvi** (ublituximab) | Multiple Sclerosis Treatment Naïve Individuals AND **ONE** of the following:<br>1. Documentation of failure or intolerance to **ONE** of the following:<br>A. dimethyl fumarate (generic for Tecfidera) [may require prior authorization]<br>B. fingolimod (generic for Gilenya) [may require prior authorization]<br>2. Documented contraindication to **BOTH** of the following:<br>A. dimethyl fumarate (generic for Tecfidera) [may require prior authorization]<br>B. fingolimod (generic for Gilenya) [may require prior authorization]<br>3. Previous treatment with Kesimpta (ofatumumab subcutaneous injection), Lemtrada (alemtuzumab intravenous infusion), Ocrevus (ocrelizumab intravenous infusion) or Tysabri (natalizumab intravenous infusion) |

**Individual and Family Plan Preferred Alternatives:**

| Product | Criteria |
|---|---|
| **Briumvi** (ublituximab) | **ONE** of the following:<br>1. Documentation of failure, contraindication, or intolerance to dimethyl fumarate (generic for Tecfidera) [may require prior authorization]<br>2. Previous treatment with Kesimpta (ofatumumab subcutaneous injection), Lemtrada (alemtuzumab intravenous infusion), Ocrevus (ocrelizumab intravenous infusion) or Tysabri (natalizumab intravenous infusion)<br>3. Currently receiving Briumvi |

**Dosing**. **ONE** of the following dosing regimens:
A. 150 mg by intravenous infusion, followed 2 weeks later by a second 450 mg intravenous infusion
B. 450 mg by intravenous infusion once every 24 weeks

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

## Reauthorization Criteria

Continuation of ublituximab (Briumvi) is considered medically necessary for Multiple Sclerosis when the above medical necessity criteria are met AND there is documentation of beneficial response.

## Authorization Duration

Initial approval duration: up to 12 months
Reauthorization approval duration: up to 12 months

## Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

**Concurrent Use with Other Disease-Modifying Agents Used for Multiple Sclerosis**.
These agents are not indicated for use in combination (see Appendix for examples). Additional data are required to determine if use of disease-modifying multiple sclerosis agents in combination is safe provides added efficacy.

## Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Considered Medically Necessary when criteria in the applicable policy statements listed above are met:**

| HCPCS Codes | Description |
|---|---|
| J2329 | Injection, ublituximab-xiiy, 1mg (Code effective 07/01/2023) |

## Background

**OVERVIEW**
Briumvi, a CD20-directed cytolytic antibody, is indicated for the treatment of relapsing forms of **multiple sclerosis** (MS), to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease, in adults.[1]

**Disease Overview**
MS is a chronic, inflammatory, demyelinating, autoimmune disease of the central nervous system that impacts almost 1,000,000 people in the US.[2-4] The condition is marked by inflammation and demyelination, as well as degenerative alterations. Patients usually experience relapses and remissions in their neurological symptoms. For most patients, the onset of MS symptoms occurs when patients are 20 to 40 years of age; however, children can get MS and new onset disease can occur in older adults. The MS disease course is heterogeneous but has some patterns. Approximately 85% to 90% of patients have a relapsing pattern at onset. However, this transitions over time in patients who are untreated to a worsening with very few or no relapses with minimal magnetic resonance imaging (MRI) activity (secondary progressive MS). Around 10% to 15% of patients have a steady progression of symptoms over time (primary progressive MS), marked by some clinical manifestations or by MRI activity. Primary progressive MS is generally diagnosed in patients on the upper level of the typical age range (e.g., almost 40 years of age) and the distribution is equivalent among the two genders.[2-4] Advances in the understanding of the MS disease process, as well as in MRI technology, spurned updated disease course descriptions in 2013,[5] as well as in 2017.[6] The revised disease courses are clinically isolated syndrome, relapsing remitting MS, primary progressive MS, and secondary progressive MS.[2-6] Clinically isolated syndrome is now more recognized among the course descriptions of MS. It is the first clinical presentation of MS that displays characteristics of inflammatory demyelination that may possibly be MS but has yet to fulfill diagnostic criteria.

**Guidelines**

Briumvi is not addressed in guidelines. In September 2019, a consensus paper was updated by the MS Coalition that discusses the use of disease-modifying therapies in MS.[2] Many options from various disease classes, involving different mechanisms of action and modes of administration, have shown benefits in patients with MS.

**Dosing and Availability**
Administer Briumvi under the close supervision of an experienced healthcare professional with access to appropriate medical support to manage severe reactions, such as serious infusion reactions.

- First Infusion: 150 mg intravenous infusion
- Second Infusion: 450 mg intravenous infusion administered two weeks after the first infusion
- Subsequent Infusions: 450 mg intravenous infusion administered 24 weeks after the first infusion and every 24 weeks thereafter.

Observe the patient for at least one hour after the completion of the first two infusions. Post-infusion monitoring of subsequent infusions is at physician discretion unless infusion reaction and/or hypersensitivity has been observed in association with the current or any prior infusion.

Injection: 150 mg/6 mL (25 mg/mL) in a single-dose vial.

**Appendix**

| Medication | Mode of Administration |
|---|---|
| Aubagio® (teriflunomide tablets) | Oral |
| Avonex® (interferon beta-1a intramuscular injection) | Injection (self-administered) |
| Bafiertam® (monomethyl fumarate delayed-release capsules) | Oral |
| Betaseron® (interferon beta-1b subcutaneous injection) | Injection (self-administered) |
| Briumvi™ (ublituximab-xiiy intravenous infusion) | Intravenous infusion |
| Copaxone® (glatiramer acetate subcutaneous injection, generic) | Injection (self-administered) |
| Extavia® (interferon beta-1b subcutaneous injection) | Injection (self-administered) |
| Gilenya® (fingolimod capsules, generic) | Oral |
| Glatopa® (glatiramer acetate subcutaneous injection) | Injection (self-administered) |
| Kesimpta® (ofatumumab subcutaneous injection) | Injection (self-administered) |
| Lemtrada® (alemtuzumab intravenous infusion) | Intravenous infusion |
| Mavenclad® (cladribine tablets) | Oral |
| Mayzent® (siponimod tablets) | Oral |
| Ocrevus® (ocrelizumab intravenous infusion) | Intravenous infusion |
| Plegridy® (peginterferon beta-1a subcutaneous or intramuscular injection) | Injection (self-administered) |
| Ponvory™ (ponesimod tablets) | Oral |
| Rebif® (interferon beta-1a subcutaneous injection) | Injection (self-administered) |
| Tascenso ODT™ (fingolimod orally disintegrating tablets) | Oral |
| Tecfidera® (dimethyl fumarate delayed-release capsules, generic) | Oral |
| Tysabri® (natalizumab intravenous infusion) | Intravenous infusion |
| Vumerity® (diroximel fumarate delayed-release capsules) | Oral |
| Zeposia® (ozanimod capsules) | Oral |

## References


1. Briumvi™ intravenous infusion [prescribing information]. Morrisville, NC: TG Therapeutics; December 2022.
2. A Consensus Paper by the Multiple Sclerosis Coalition. The use of disease-modifying therapies in multiple sclerosis. Updated September 2019. Available at: https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/DMT_Consensus_MS_Coalition.pdf. Accessed on December 30, 2022.

3. McGinley MP, Goldschmidt C, Rae-Grant AD. Diagnosis and treatment of multiple sclerosis. A review. *JAMA*. 2021; 325(8):765-779.
4. The Medical Letter on Drugs and Therapeutics. Drugs for multiple sclerosis. *Med Lett Drugs Ther*. 2021; 63(1620):42-48.
5. Lublin FD, Reingold SC, Cohen JA, et al. Defining the clinical course of multiple sclerosis: the 2013 revisions. Neurology. 2014; 83:278-286.
6. Thompson AJ, Banwell BL, Barkhof F, et al. Diagnosis of multiple sclerosis: 2017 revisions of the McDonald criteria. Lancet Neurol. 2018; 17(2):162-173.