Mass General Brigham
Health Plan

Lunsumio (mosunetuzumab-axgb)
Effective 07/31/2023

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
Lunsumio (mosunetuzumab-axgb) is an intravenous "off-the-shelf" T-cell-redirecting, bispecific antibody that is indicated for the treatment of adult patients with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy.

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, and documentation is provided:

1. Diagnosis of relapsed or refractory follicular lymphoma (FL)
2. Prescriber is a hematologist or oncologist
3. Appropriate dosing
4. Member is ≥ 18 years of age on treatment date
5. Member has failed ≥ 2 lines of systemic therapies including at least one anti-CD20 monoclonal antibody *(e.g., rituximab, obinutuzumab – see Appendix for more)*

Limitations

1. Initial approvals will be granted for 6 months.
2. Reauthorizations: There is currently no data to support repeat dosing of extended use of Lunsumio beyond 17 cycles. Requests for reauthorization will be reviewed on a case by case basis.
3. **Requests for Brand Name when generic is preferred:** In addition to any prior authorization requirements that may be listed above, if an A-rated generic equivalent is available, such prior authorization requests require medical records documenting an allergic response, adverse reaction, or

inadequate response to the generic equivalent drug (history of allergic reaction to the inactive ingredients used in the manufacturing process of a certain drug is acceptable).

4. **Requests for generic when Brand Name is preferred:** There are some drugs for which the Plan has determined it will be cost effective to prefer the use of the Brand Name formulation. In this case, the generic equivalent formulation is considered non-preferred and requires prior authorization. These requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the Brand Name formulation. For the most up to date list of drugs where the Brand Name formulation is preferred, see the MassHealth Brand Name Preferred Over Generic Drug List (BOGL) at www.mass.gov/druglist.

Appendix

Commonly Used Regimens for FL

According to the NCCN guidelines, the following regimens may be used for the treatment of FL:

- Bendamustine + rituximab or obinutuzumab
- CHOP (cyclophosphamide, doxorubicin, vincristine and prednisone) + rituximab or obinutuzumab
- CVP (cyclophosphamide, vincristine and prednisone) + rituximab or obinutuzumab
- Lenalidomide + rituximab
- Single agent rituximab or obinutuzumab

References

1. Lunsumio® [package insert on the internet]. South San Francisco (CA): Genentech; 2022 Dec [cited 2023 Feb 16]. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/761263s000lbl.pdf.

Review History

07/12/23 - Reviewed and created for P&T. New drug, Lunsumio (mosunetuzumab-axgb), will require PA through medical benefit. Effective 7/31/23.