Mass General Brigham
Health Plan

Multiple Sclerosis Agents
Briumvi (ublituximab-xiiy)
Effective 05/12/2025

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	Briumvi is also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Briumvi 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.

Coverage Guidelines
Authorizations requests will be reviewed on a case by case basis for members new to the plan 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:

Briumvi (ublituximab-xiiy)
1. Diagnosis of **ONE** of the following:
    a. clinically isolated syndrome
    b. relapse-remitting multiple sclerosis
    c. active secondary-progressive multiple sclerosis
2. Prescriber is a neurologist or consult notes from a neurology office are provided
3. Requested dose is 450 mg IV every 24 weeks (if member is initiating therapy, first dose is given as a 150 mg infusion on day 1 followed by a 450 mg infusion two weeks later)

Continuation of Therapy
- For **RRMS**: Reauthorization requires physician attestation of continuation of therapy and positive response to therapy.

- For **SPMS**: Reauthorization requires physician attestation of active disease, continuation of therapy and positive response to therapy.
- For **CIS**: Reauthorization will be evaluated on a case by case basis.

Limitations

1. Initial authorizations and reauthorizations will be granted for 12 months.

References

1. National Multiple Sclerosis Society [homepage on the internet]. National Multiple Sclerosis Society; 2014 [cited 2014 Aug 15]. Available at: http://www.nationalmssociety.org/.
2. Fox RJ, Miller DH, Phillips T, Hutchinson M, Havrdova E, Kita M et al. Placebo-controlled phase 3 study of oral BG-12 or glatiramer in multiple sclerosis. N Engl J Med. 2012;367:1087-97.
3. Gold R, Kappos L, Arnold DL, Bar-Or A, Giovannoni G, Selmaj K et al. Placebo-controlled phase 3 study of oral BG-12 for relapsing multiple sclerosis. N Engl J Med. 2012(a);367:1098-107.
4. Goodin DS, Frohman EM, Garmany GP. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002;58(2):169-78.
5. Briumvi [package insert]. Morrisville (NC): TG Therapeutics; 2025 Feb.

Review History

04/25/2016 – Reviewed
04/24/2017 – Reviewed
04/17/2019 – Reviewed in P&T Meeting
10/06/2020 – Effective 1/1/21 Updated to be in compliance with the Masshealth partial unified formulary requirements
05/19/2021 – Reviewed and Updated per MH UPPL; Vumerity added as an acceptable trial for certain agents (Mayzent, Zeposia). Mayzent and Zeposia criteria updated to have medical necessary use of Gilenya and previous use of ONE other medication. Verbiage changes for "Prescriber is a neurologist or consult notes from a neurology office are provided". Effective 07/01/2021
11/17/2021 – Reviewed and Updated; Updated to include 2 new agents Ponvory and Mavenclad. Aubagio will be preferred. Matched criteria to MH UPPL for effective 1/1/22
03/16/2022 – Reviewed and Updated for March P&T; Guideline updated to reflect that Gilenya is no longer brand preferred. Clarified Gilenya criteria to remove question requiring step through of the generic as the agent is not yet generically available. Effective 5/1/22.
11/16/2022 – Reviewed and updated for November P&T. Gilenya becomes a brand preferred product as the generic fingolimod becomes available. Tecfidera was removed as a brand preferred product. Effective 2/1/23.
03/15/23 - Reviewed and updated for Mar P&T. Added criteria for Extavia, Ocrevus, Plegridy, Tascenso to policy. Changed Gilenya to fingolimod capsules throughout policy. Effective 4/1/23.
05/10/23 – Reviewed and updated for P&T. Updated policy to include new strength and criteria for Tascenso ODT 0.5 mg. Added weight requirement to Tascenso ODT. Effective 6/5/23
07/12/23 – Reviewed and updated for P&T. Brand preferred and mandatory generic language was added under Limitations. Added new drug, Briumvi® (ublituximab-xiiy), requiring PA through pharmacy and medical benefits. Briumvi was added as a step through option for Ocrevus for requests under PB. Dalfampridine, dimethyl fumarate, fingolimod and teriflunomide will only require PA if above QL. Effective 7/31/23
09/13/23 – Reviewed and updated for P&T. Consolidated Ocrevus and Briumvi into a single alternative option given the same mechanism of action. Effective 10/2/23
04/9/25 – Reviewed and updated for P&T. Performed annual medical criteria review. Policy has been updated to better reflect agents with prior authorization on medical benefit. All agents except for Briumvi and Ocrevus were

pharmacy benefit only and thus have been removed. Ocrevus and Briumvi will have individual policies. Updated formatting & references accordingly. No clinical changes made. Effective 5/12/25