Mass General Brigham
Health Plan

Multiple Sclerosis Agents
Lemtrada (alemtuzumab)
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	Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Lemtrada is a monoclonal antibody disease-modifying drugs indicated for relapse remitting multiple sclerosis (RRMS) and active secondary progressive multiple sclerosis (SPMS) in adults. Because of its safety profile, the use of Lemtrada should generally be reserved for patients who have had an inadequate response to two or more drugs indicated for the treatment of MS.

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:

1. Diagnosis of **ONE** of the following:
    a. relapse-remitting multiple sclerosis
    b. confirmed active secondary-progressive multiple sclerosis
2. Prescriber is a neurologist or consult notes from a neurology office are provided
3. Paid claims or physician attestation of inadequate response or adverse reaction to **TWO** or contraindication to **ALL** of the following disease modifying multiple sclerosis agents:
    a. teriflunomide
    b. Briumvi (ublituximab-xiiy) or Ocrevus Zunovo (ocrelizumab/hyaluronidase-ocsq)
    c. dimethyl fumarate or Vumerity
    d. fingolimod capsule
    e. glatiramer acetate therapy
    f. interferon therapy
    g. Tysabri (natalizumab)
4. Requested dose is for **ONE** of the following:
    a. 12 mg daily for 5 days in 1st year of therapy

b. 12 mg daily for 3 days in 2nd year of therapy

Continuation of Therapy

1. Reauthorization by prescriber will infer a positive response to therapy
2. For diagnosis of SPMS, prescriber provided attestation confirming active disease

Limitations

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

References

1. Lemtrada [package insert]. Cambridge, MA: Genzyme Corporation; July 2016.

Review History

11/18/2020 – Transitioned from SGM to Custom Criteria; separated MH vs. Comm/Exch
03/15/23 - Reviewed and updated for Mar P&T. Matched MH UPPL criteria to be in compliance with Masshealth unified formulary requirements. Effective 4/1/23.
07/12/23 – Reviewed and updated for P&T. Added Briumvi as another step through option. Brand preferred and mandatory generic language was added under Limitations. 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
10/9/24 – Reviewed and updated for P&T. Formatting updates. Effective 11/12/24
4/9/25 – Reviewed and updated for P&T. Ocrevus Zunovo will be added as a trial option in place of Ocrevus. Effective 5/12/25