

Briumvi® (Ublituximab-Xiyy)

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Community Plan Policy
<ul style="list-style-type: none"> Briumvi® (Ublituximab-Xiyy)

Coverage Rationale

[➔ See Benefit Considerations](#)

Briumvi (ublituximab-xiyy) is proven for the treatment of relapsing forms of multiple sclerosis (MS). Briumvi is medically necessary for the treatment of relapsing forms of multiple sclerosis (MS) when all of the following criteria are met:

- For **initial therapy**, all of the following:
 - Diagnosis of relapsing forms of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses); **and**
 - Patient is **not** receiving Briumvi in combination with **any** of the following:
 - Disease modifying therapy (e.g., interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, or teriflunomide)
 - B cell targeted therapy (e.g., rituximab, belimumab, ofatumumab, ocrelizumab)
 - Lymphocyte trafficking blockers (e.g., alemtuzumab, mitoxantrone)
 - and**
 - Briumvi dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Initial authorization is for no more than 12 months.
- For **continuation of therapy**, all of the following:
 - Patient has previously received treatment with Briumvi; **and**
 - Documentation of positive clinical response to Briumvi therapy; **and**
 - Patient is **not** receiving Briumvi in combination with **any** of the following:
 - Disease modifying therapy (e.g., interferon beta preparations, dimethyl fumarate, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, or teriflunomide)
 - B cell targeted therapy (e.g., rituximab, belimumab, ofatumumab, ocrelizumab)
 - Lymphocyte trafficking blockers (e.g., alemtuzumab, mitoxantrone)
 - and**
 - Briumvi dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Authorization is for no more than 12 months.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J2329	Injection, ublituximab-xiyy, 1mg

Diagnosis Code	Description
G35	Multiple sclerosis

Background

Briumvi a recombinant chimeric monoclonal antibody directed against CD20-expressing B-cells. The precise mechanism by which Briumvi exerts its therapeutic effects in multiple sclerosis is unknown, but is presumed to involve binding to CD20, a cell surface antigen present on pre-B and mature B lymphocytes. Following cell surface binding to B lymphocytes, Briumvi results in cell lysis through mechanisms including antibody-dependent cellular cytotoxicity and complement-dependent cytotoxicity.

Benefit Considerations

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. Refer to the Policy and Procedure addressing the treatment of serious rare diseases.

Clinical Evidence

Proven

Relapsing Forms of Multiple Sclerosis (RMS)

The efficacy of Briumvi was demonstrated in two randomized, double-blind, double-dummy, parallel group, active comparator-controlled clinical trials of identical design, in patients with RMS treated for 96 weeks (ULTIMATE I and II). Patients were randomized to receive either Briumvi, given as an IV infusion of 150 mg for the first infusion, 450 mg two weeks after the first infusion for the second infusion/second dose, and 450 mg every 24 weeks after the first infusion for subsequent doses (third infusion and beyond) with oral placebo administered daily; or teriflunomide, the active comparator, given orally as a 14 mg daily dose with IV placebo administered on the same schedule as BRIUMVI. Both studies enrolled patients who had experienced at least one relapse in the previous year, two relapses in the previous two years, or had the presence of a T1 gadolinium (Gd)-enhancing lesion in the previous year. Patients were also required to have an Expanded Disability Status Scale (EDSS) score from 0 to 5.5 at baseline. Neurological evaluations were performed at baseline, every 12 weeks, and at the time of a suspected relapse. Brain MRI scans were performed at baseline and at Weeks 12, 24, 48, and 96.

The primary outcome of both ULTIMATE I and II was the annualized relapse rate (ARR) over the treatment period. Additional outcome measures included: the total number of MRI T1 Gdenhancing lesions by Week 96, the total number of new or enlarging MRI T2 hyperintense lesions by Week 96, and time to confirmed disability progression for at least 12 weeks. Disability progression was defined as an increase of greater than or equal to 1.0 point from the baseline EDSS score that was attributable to MS when the baseline score was 5.5 or less, and greater than or equal to 0.5 points when the baseline score was above 5.5. Confirmed disability progression was evaluated in a pooled analysis of ULTIMATE I and II. Disability progression was

considered confirmed when the increase in the EDSS was confirmed at a regularly scheduled visit 12 weeks after the initial documentation of neurological worsening.

A total of 549 participants were enrolled in the ULTIMATE I trial, and 545 were enrolled in the ULTIMATE II trial; the median follow-up was 95 weeks. In the ULTIMATE I trial, the annualized relapse rate was 0.08 with ublituximab and 0.19 with teriflunomide [rate ratio, 0.41; 95% confidence interval (CI), 0.27 to 0.62; P < 0.001]; in the ULTIMATE II trial, the annualized relapse rate was 0.09 and 0.18, respectively (rate ratio, 0.51; 95% CI, 0.33 to 0.78; P = 0.002). The mean number of gadolinium-enhancing lesions was 0.02 in the ublituximab group and 0.49 in the teriflunomide group (rate ratio, 0.03; 95% CI, 0.02 to 0.06; P < 0.001) in the ULTIMATE I trial and 0.01 and 0.25, respectively (rate ratio, 0.04; 95% CI, 0.02 to 0.06; P < 0.001), in the ULTIMATE II trial. In the pooled analysis of the two trials, 5.2% of the participants in the ublituximab group and 5.9% in the teriflunomide group had worsening of disability at 12 weeks (hazard ratio, 0.84; 95% CI, 0.50 to 1.41; P = 0.51). Infusion-related reactions occurred in 47.7% of the participants in the ublituximab group. Serious infections occurred in 5.0% in the ublituximab group and in 2.9% in the teriflunomide group.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

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.

References

1. Briumvi [package insert]. Morrisville, NC: TG Therapeutics, Inc.; December 2022.
2. Steinman L, Fox E, Hartung HP, et al. Ublituximab versus Teriflunomide in Relapsing Multiple Sclerosis. N Engl J Med. 2022;387(8):704-714.

Policy History/Revision Information

Date	Summary of Changes
05/01/2024	<p>Coverage Rationale</p> <ul style="list-style-type: none">• Changed duration for initial authorization from “no more than 6 months” to “no more than 12 months” <p>Supporting Information</p> <ul style="list-style-type: none">• Archived previous policy version 2023D00122B

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent

professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.