Reference number
5738-A

Aetna Medicare Part B Drug Criteria

Briumvi

This policy is for Aetna Medicare members. Find the Aetna Commercial Medical Drug Criteria.

For Aetna Medicare members, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) will be applied to Part B drug requests when applicable. Aetna Medicare Part B Drug Criteria documents will be used in the absence of an NCD and LCD.

POLICY

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Briumvi	ublituximab-xiiy

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication[1]

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.

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

Coverage Criteria

© 2026 Aetna Inc.

This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Aetna Inc.

Reference number
5738-A

Relapsing Forms of Multiple Sclerosis (MS)[1]

Authorization of 12 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse).

Clinically Isolated Syndrome[1]

Authorization of 12 months may be granted to members for the treatment of clinically isolated syndrome of multiple sclerosis.

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:

- The member is currently receiving therapy with Briumvi.
- Briumvi is being used to treat an indication in the coverage criteria.
- The member is receiving benefit from therapy.

Summary of Evidence

The contents of this policy were created after examining the following resources:

- The prescribing information for Briumvi.
- The available compendium
    - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
    - Micromedex DrugDex
    - American Hospital Formulary Service- Drug Information (AHFS-DI)
    - Lexi-Drugs
    - Clinical Pharmacology

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Briumvi are covered.

Explanation of Rationale

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

Reference

1. Briumvi [package insert]. Morrisville, NC: TG Therapeutics, Inc.; October 2024.

© 2026 Aetna Inc.

This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Aetna Inc.

Reference number
5738-A

CPT Codes / HCPCS Codes / ICD-10 Codes

Code	Description
Other CPT codes related to the CPB:	
96365-96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug)
HCPCS codes covered if selection criteria are met:	
J2329	Injection, ublituximab-xiiy, 1mg
ICD-10 codes covered if selection criteria are met:	
G35	Multiple sclerosis [relapsing-remitting and secondary progressive disease]
G37.89	Other specified demyelinating diseases of central nervous system [Clinically isolated syndrome of Multiple sclerosis]

Revision History

Date	Version	Update	Revisions
01/01/2024	2023	New Criteria	Policy effective.
03/28/2024	2023a	Annual Review	Medicare Utilization Management Committee approved.
04/24/2025	2024	Annual Review	Medicare Utilization Management Committee approved.
03/26/2026	2025	Annual Review	Medicare Utilization Management Committee approved.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

© 2026 Aetna Inc.

This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Aetna Inc.