

POLICY NAME	Lemtrada (alemtuzumab)	POLICY #	2362P
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Criteria

Coverage Criteria

- ☐ 1.1 Diagnosis of relapsing forms of multiple sclerosis with intent to reduce the frequency of clinically acute worsening of disease, OR diagnosis of first clinical episode and have MRI features consistent with multiple sclerosis
- ☐ 1.2 Prescribed by a neurologist (nervous system doctor)
- ☐ 1.3 Documented failure, intolerance, or contraindication to Ocrevus and one additional disease-modifying therapy for Multiple Sclerosis (MS) such as Aubagio

Exclusion Criteria – Any of the following prevents coverage

- ☐ 2.1 Documentation of HIV Infection
- ☐ 2.2 Documentation of a primary progressive disease course