MEDICATION POLICY

Generic Name: Teriflunomide

Therapeutic Class or Brand Name: Aubagio®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 5/28/16 **Date Last Reviewed/Revised:** 11/16/17

GPI Code: 6240407000

Prior Authorization Criteria (may be considered medically necessary when criteria I through IV are met):

I. Documented diagnosis of a relapsing form of multiple sclerosis.

II. Minimum age requirement: 18 years old.

III. Prescribing physician must be a neurologist or a multiple sclerosis physician specialist.

IV. Documented trial and failure of, intolerance to, or contraindication to two preferred products (refer to plan document for the list of preferred products).

Exclusion Criteria:

- Coadministration of Aubagio® with another disease-modifying multiple sclerosis therapy such as Avonex® (interferon beta-1a), Betaseron® (interferon beta-1b), Copaxone® (glatiramer), Extavia® (interferon beta-1b), Gilenya® (fingolimod), Glatopa™ (glatiramer), Lemtrada® (alemtuzumab), Novantrone® (mitoxantrone), Ocrevus™ (ocrelizumab), Plegridy® (peginterferon beta-1a), Rebif® (interferon beta-1a), Tecfidera® (dimethyl fumarate), Tysabri® (natalizumab), or Zinbryta™ (daclizumab).
- Severe hepatic impairment.
- Pregnancy.
- Current leflunomide treatment.

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- 30 tablets per 30 days.

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Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. http://products.sanofi.us/aubagio/aubagio.pdf.
2. Medi-Span.
3. http://blue.regence.com/trgmedpol/drugs/dru283.pdf.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
11/16/2017	1. **Added** "Ocrevus™ (ocrelizumab)" **to list of drugs following the statement** "Coadministration of Aubagio® with another disease-modifying multiple sclerosis therapy such as …" **under Exclusion Criteria**.