



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: 05/14/2018

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.

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.



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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. <https://tuftshealthplan.com/documents/providers/guidelines/pharmacy-medical-necessity-guidelines/thpp-aubagio-teriflunomide>
2. <http://products.sanofi.us/aubagio/aubagio.pdf>
3. Medi-Span.

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<i>Historical Tracking Of Changes Made To Policy</i>	
5/14/2018	1. Added https://tuftshealthplan.com/documents/providers/guidelines/pharmacy-medical-necessity-guidelines/thpp-aubagio-teriflunomide and Deleted http://blue.regence.com/trgmedpol/drugs/dru283.pdf .” Under References
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.

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