

## PHARMACY POLICY STATEMENT

### Georgia Medicaid

DRUG NAME	Aubagio (teriflunomide)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT — 30 tabs for 30 days
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Aubagio (teriflunomide) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis.
4. **Dosage allowed:** 7 or 14 mg orally once daily.

***If member meets all the requirements listed above, the medication will be approved for 12 months.***

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.***

CareSource considers Aubagio (teriflunomide) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Aubagio created. Not covered diagnosis added.
12/06/2017	Age coverage expanded. Confirmation of diagnosis based on McDonald criteria is no longer required.

References:



1. Aubagio [package insert]. Cambridge, MA; Genzyme, Inc. November 2016.
2. Aubagio. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: <http://www.micromedexsolutions.com>. Accessed March 16, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. *Neurology*. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. *Annals of Neurology*. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 12/20/2017

Revised date: 12/06/2017