Reference number(s) 1808-A

# SPECIALTY GUIDELINE MANAGEMENT

# **AUBAGIO (teriflunomide)**

#### POLICY

### I. INDICATIONS

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

<u>FDA-Approved Indication</u>: Aubagio is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefits.

## **II. CRITERIA FOR INITIAL APPROVAL**

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

### **III. CONTINUATION OF THERAPY**

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

#### IV. REFERENCE

1. Aubagio [package insert]. Cambridge, MA: Genzyme Corporation; November 2016.

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