Clinical Policy: Teriflunomide (Aubagio)

Reference Number: PA.CP.PHAR.262
Effective Date: 01/18
Last Review Date: 04/19 Revision Log

Description
Teriflunomide (Aubagio®) is a pyrimidine synthesis inhibitor.

FDA Approved Indication(s)
Aubagio is indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS).

Policy/Criteria
It is the policy of Pennsylvania Health and Wellness® that Aubagio is **medically necessary** for the following indications:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all):

1. Diagnosis of a relapsing form of multiple sclerosis (MS);
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. Failure of one of the following (a or b) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced or patient has been previously established and stabilized on therapy:
   a. Avonex® or Plegridy® and any of the following: glatiramer (*generic [including Glatopa®] is preferred*), Tecfidera®, Gilenya™;
   b. Any 2 of the following agents: glatiramer acetate (*generic [including Glatopa®] is preferred*), Tecfidera, Gilenya;
5. Member will not use other disease modifying therapies for MS concurrently (*see Appendix D*);
6. At the time of request, member is not receiving leflunomide;
7. Dose does not exceed 14 mg (1 tablet) per day.

Approval duration: 6 months

B. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

A. Multiple Sclerosis (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. Member is not using other disease modifying therapies for MS concurrently (*see Appendix D*);
4. If request is for a dose increase, new dose does not exceed 14 mg (1 tablet) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Pennsylvania Health and Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;

Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to PA.CP.PMN.53.

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MS: multiple sclerosis

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Avonex®, Rebif® (interferon beta-1a)	*Avonex*: 30 mcg IM Q week *Rebif*: 22 mcg or 44 mcg SC TIW	*Avonex*: 30 mcg/week *Rebif*: 44 mcg TIW
Plegridy® (peginterferon beta-1a)	125 mcg SC Q2 weeks	125 mcg/2 weeks
Betaseron®, Extavia® (interferon beta-1b)	250 mcg SC QOD	250 mg QOD
glatiramer acetate (Copaxone®, Glatopa®)	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Gilenya™ (fingolimod)	0.5 mg PO QD	0.5 mg/day
Tecfidera® (dimethyl fumarate)	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): severe hepatic impairment; pregnancy or females of reproductive potential not using effective contraception; hypersensitivity to teriflunomide, leflunomide or any inactive ingredients in Aubagio; current leflunomide treatment
- Boxed warning(s): hepatoxocity, risk of teratogenicity

Appendix D: General Information
- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone®, Glatopa®), interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®), peginterferon beta-1a (Plegridy®), dimethyl fumarate (Tecfidera®), fingolimod

(Gilenya™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), and ocreliuzmab (Ocrevus™).

- Teriflunomide is the principal active metabolite of leflunomide and is responsible for leflunomide's activity in vivo. At recommended doses, teriflunomide and leflunomide result in a similar range of plasma concentrations of teriflunomide.

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Relapsing MS	7 or 14 mg PO QD with or without food	14 mg/day

V. Product Availability

Tablets: 7 mg, 14 mg

Reviews, Revisions, and Approvals	Date	Approval Date
2Q 2018 annual review: removed contraindication; references reviewed and updated.	01.05.18	
2Q 2019 annual review: specified that generic forms of glatiramer are preferred; references reviewed and updated.	04.17.19	

References

1. Aubagio Prescribing Information. Cambridge, MA: Genzyme Corporation; November 2016. Available at http://www.aubagio.com. Accessed February 4, 2019.
2. Costello K, Halper J, Kalb R, Skutnik L, Rapp R. The use of disease-modifying therapies in multiple sclerosis, principles and current evidence – a consensus paper by the Multiple Sclerosis Coalition. March 2017. Accessed February 4, 2019.
3. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis: report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology. 2018; 90(17): 777-788. Full guideline available at: https://www.aan.com/Guidelines/home/GetGuidelineContent/904.