Clinical Policy: Teriflunomide (Aubagio)
Reference Number: CP.PHAR.262
Effective Date: 08.01.16
Last Review Date: 05.19
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

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

FDA Approved Indication(s)
Aubagio is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Aubagio is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Multiple Sclerosis (must meet all):
      1. Diagnosis of one of the following (a, b, or c):
         a. Clinically isolated syndrome;
         b. Relapsing-remitting MS;
         c. Secondary progressive MS;
      2. Prescribed by or in consultation with a neurologist;
      3. Age ≥ 18 years;
      4. Aubagio is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
      5. At the time of request, member is not receiving leflunomide;
      6. Dose does not exceed 14 mg (1 tablet) per day.

   Approval duration: 6 months

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.
II. Continued Therapy
   A. Multiple Sclerosis (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. Aubagio is not prescribed concurrently with other disease modifying therapies for MS (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 Centene benefit and documentation supports positive response to therapy.
         Approval duration: Duration of request or 6 months (whichever is less); or
      2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents;
   B. Primary progressive MS.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration
   MS: multiple sclerosis

   Appendix B: Therapeutic Alternatives
   Not applicable

   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): hepatotoxicity, 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 ocreliuzumab (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.

V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tr>
<td>Relapsing MS</td>
<td>7 or 14 mg PO QD with or without food</td>
<td>14 mg/day</td>
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VI. Product Availability

Tablets: 7 mg, 14 mg

VII. References


Reviews, Revisions, and Approvals

| Policy split from CP.PHAR.18 MS Treatments. Criteria: added max dosing, clarified monotherapy restriction, removed re-authorization requirement for documented adherence, updated contraindications and reasons to discontinue, modified efficacy criteria to “Responding positively to therapy”. Modified renewal approval duration to 12 months. Requirement for the trial and failure of at least 2 preferred regimens from different classes added. Removed specific strength requirement from glatiramer. | 06.16 | 08.16 |
| Added age requirement. Removed MRI requirement. Removed hypersensitivity reaction and active infection contraindications. Removed reasons to discontinue. | 07.17 | 08.17 |
| 2Q 2018 annual review: no significant changes; removed severe hepatic impairment as a contraindication per safety guidance endorsed by Centene Medical Affairs; references reviewed and updated. | 01.05.18 | 05.18 |
| 2Q 2019 annual review: no significant changes; specified that generic forms of glatiramer are preferred; references reviewed and updated. | 02.04.19 | 05.19 |
| New language added to existing indication as shown in the following parenthetical: Aubagio is indicated for the treatment of relapsing forms of MS (to include clinically isolated syndrome, relapsing-remitting | 12.05.19 |
Reviews, Revisions, and Approvals

<table>
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<tr>
<th>disease, and active secondary progressive disease, in adults) - criteria reconciled.</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tr>
<td>Per SDC CY2020 strategy: removed all re-directions.</td>
<td>12.09.19</td>
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**Important Reminder**
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.
CLINICAL POLICY
Teriflunomide

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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