Pharmacy Medical Necessity Guidelines: Aubagio® (teriflunomide)

Effective: June 13, 2017

Prior Authorization Required: ✓
Type of Review – Care Management

Not Covered: ✓
Type of Review – Clinical Review

Pharmacy (RX) or Medical (MED) Benefit: RX
Department to Review: RXUM

Fax Numbers:
RXUM: 617.673.0988

This Pharmacy Medical Necessity Guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- ✓ Tufts Health Together – A MassHealth Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan – large group plans
- Tufts Health Freedom Plan – small group plans

OVERVIEW

Multiple sclerosis (MS) is a chronic disease of the central nervous system (CNS) characterized by inflammation, demyelination, and axonal degeneration. It is estimated to affect more than 2.3 million people worldwide. More people are being diagnosed with MS today compared to the past, but there is no definitive evidence available to confirm the rate of MS is increasing. Reasons for the increase in the number of people being diagnosed could be explained by greater disease awareness, better access to medical care, and improved diagnostic capabilities. Most people are diagnosed between the ages of 20 and 50, although MS can occur in young children and significantly older adults. While the disease occurs in most ethnic groups, it is most common among Caucasians of northern European ancestry. Because MS is at least two to three times more common in women than in men, it has been suggested that hormones also play a significant role in determining susceptibility to MS.

It is believed that MS consists of both inflammatory and neurodegenerative components. Inflammation may be related to acute relapses, and it is believed that these acute attacks are associated with axon damage which leads to permanent neurologic dysfunction. The neurodegenerative component may contribute to the progressive disability that occurs over time.

The symptoms and severity of MS vary, and the course of the disease in an individual patient is often unpredictable. Common symptoms include sensory disturbances in the limbs leading to gait and balance problems, optic nerve dysfunction and vision loss, dysphagia, bladder or bowel dysfunction, sexual dysfunction, fatigue, emotional lability, and cognitive impairment. It is estimated that 50% of untreated patients will require an assistive walking device within 15 years of disease onset.

Four categories of MS are recognized. Approximately 85% of patients are initially classified as having relapsing-remitting MS (RRMS) which is characterized by episodic relapses with partial or complete remissions. The majority of patients with RRMS will go on to develop secondary progressive MS (SPMS) which is characterized by an initial period of relapses and remissions, followed by a sudden progressive decrease in CNS function without periods of remission. Primary progressive MS (PPMS) is characterized by a steady decrease in CNS function from the onset without remissions or clear attacks. In contrast, patients with progressive-relapsing MS (PRMS) experience a steady decrease in CNS function from the onset and have clearly identifiable attacks. PPMS is the initial diagnosis in approximately 10% of patients while 5% of patients have PRMS.

Symptomatic management is directed toward alleviating complications of MS. Treatment options include the use of urinary antispasmodics for bladder urgency, muscle relaxants to relieve spasticity, antidepressants, and pain management (e.g., gabapentin, carbamazepine, duloxetine). Ampyra (dalfampridine) is the first symptomatic therapy indicated to improve walking in patients with MS. Acute attacks of MS can be managed with the use of intravenous corticosteroids.

Chronic management of MS involves prevention of relapses as well as symptomatic management. Disease-modifying agents such as interferon beta-1b (e.g., Betaseron, Extavia), interferon beta-1a (e.g., Avonex, Rebif), Copaxone (glatiramer acetate), and Gilenya (fingolimod) have been shown to reduce the number and severity of relapses and may reduce long-term progression of MS. The interferon products and Gilenya (fingolimod) are indicated for relapsing forms of MS (RRMS and PRMS) while Copaxone (glatiramer) is only indicated for RRMS. The β-interferons have the potential to...
produce flu-like symptoms, fatigue, and/or depression, whereas Copaxone (glatiramer) does not have a risk for these events, although Copaxone (glatiramer) is not indicated for delaying the accumulation of physical disability.

Other agents indicated to prevent relapse include Tysabri (natalizumab) (for RRMS and PRMS) and Novantrone (mitoxantrone) (for SPMS, PRMS, and worsening RRMS). Tysabri (natalizumab) can be used for patients who have failed other therapies or who have a particularly aggressive initial disease course, although there is a risk of potentially fatal cases of progressive multifocal encephalopathy (PML), thereby limiting its use. Novantrone (mitoxantrone) is the only agent indicated for SPMS and it does not produce the flu-like symptoms, fatigue, and/or depression often associated with the β-interferons, although there is a risk of cardiac and hematological toxicity.

Aubagio (teriflunomide) is a pyrimidine synthesis inhibitor. It is the second oral disease-modifying MS treatment approved by the Food and Drug Administration (FDA). With the approval of oral disease-modifying therapies, the therapeutic strategy for treatment of RRMS has evolved to include efficacious options that have administration advantages over established parenteral options.

**FDA-APPROVED INDICATIONS**

Aubagio (teriflunomide) is indicated for the treatment of patients with relapsing forms of MS (relapsing-remitting MS, progressive-relapsing MS, and secondary progressive MS with relapse).

**COVERAGE GUIDELINES**

The plan may authorize coverage of Aubagio (teriflunomide) for Members when all the following criteria for a particular regimen are met and limitations do not apply:

1. The Member has a diagnosis of relapsing form of Multiple Sclerosis

   **AND**

2. The Member has tried and failed, or the provider has documented clinical inappropriateness of treatment with at least one of the following medications: Rebif, Avonex, Betaseron, Extavia, Copaxone or Tysabri

   **AND**

3. The Member is new to and has been stabilized on Aubagio (teriflunomide) prior to enrollment

**LIMITATIONS**

1. The following quantity limitations apply for Aubagio (teriflunomide):

   | Aubagio (teriflunomide) | 30 tablets per month |

**CODES**

None

**REFERENCES**

5. Extavia (interferon beta-1b) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; 2016 May.
7. Gilenya (fingolimod) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; 2016 February.

**APPROVAL HISTORY**
March 14, 2013: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- June 4, 2014: No changes.
- June 9, 2015: No changes.
- January 1, 2016: Administrative change to rebranded template.
- June 14, 2014: No changes.
- June 13, 2017: No changes.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.