blue of california

teriflunomide tablet (AUBAGIO)

Diagnosis Considered for Coverage:

- Multiple sclerosis (MS)

Coverage Criteria:

For diagnosis listed above:

- Dose does not exceed FDA label maximum, **and**
- Not being used in combination with another multiple sclerosis disease modifying therapy, **and**
- Inadequate response or intolerable side effect to ONE preferred MS agent (e.g., Extavia, fingolimod, dimethyl fumarate, glatiramer, Glatopa) OR contraindication to all preferred MS agents.

Coverage Duration: one year

Effective Date: 1/31/2024