CONTAINS CONFIDENTIAL PATIENT INFORMATION

Aubagio (teriflunomide)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Aubagio (teriflunomide)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No	Patient has had a previous trial and therapy failure with a preferred* interferon or non-interferon used to treat multiple sclerosis **If No:**
	☐ Yes ☐ No Documented evidence is provided that the use of these agents would be medically contraindicated
☐ Yes ☐ No	Patient has a diagnosis of relapsing forms of multiple sclerosis
☐ Yes ☐ No	Documentation is provided that the patient does not have severe hepatic impairment
☐ Yes ☐ No	Documentation is provided of a negative pregnancy test for females of childbearing age
☐ Yes ☐ No	Documentation is provided of use of a reliable form of contraception for females of childbearing age
☐ Yes ☐ No	Documentation is provided that the patient is not taking leflunomide
☐ Yes ☐ No	Patient is 18 years of age or older

*The preferred Interferons are: Rebif, Rebif Rebidose, Rebif Rebidose Titrationpack, Betaseron, Avonex, Avonex Pen.
The preferred Non-Interferons are: Copaxone Sosy 20MG/ML, Gilenya.

Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

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Patient Name: _____ **Patient ID#:** _____

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.