

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: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Aubagio (teriflunomide)	_____	_____	Specify: _____
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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.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has had a previous trial and therapy failure with a preferred* interferon or non-interferon used to treat multiple sclerosis If No:
		<input type="checkbox"/> Yes <input type="checkbox"/> No Documented evidence is provided that the use of these agents would be medically contraindicated
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis of relapsing forms of multiple sclerosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Documentation is provided that the patient does not have severe hepatic impairment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Documentation is provided of a negative pregnancy test for females of childbearing age
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Documentation is provided of use of a reliable form of contraception for females of childbearing age
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Documentation is provided that the patient is not taking leflunomide
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is 18 years of age or older
<p>*The preferred Interferons are: Rebif, Rebif Rebidose, Rebif Rebidose Titrationpack, Betaseron, Avonex, Avonex Pen. The preferred Non-Interferons are: Copaxone Sosy 20MG/ML, Gilenya.</p> <p>Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.</p>		



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9. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
<small><i>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.</i></small> <small><i>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</i></small>	
<small>The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.</small>	