Drug Coverage Policy

Effective Date.....9/15/2026
Coverage Policy Number.....IP0560
Policy Title.....Teriflunomide for Individual and Family Plans

Multiple Sclerosis (Oral – Other) - Teriflunomide for Individual and Family Plans

- Aubagio® (teriflunomide tablets - Genzyme/Sanofi, generic)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW
Teriflunomide, a pyrimidine synthesis inhibitor, is indicated for the treatment of patients with relapsing forms of **multiple sclerosis** (MS) to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.[1]

Guidelines
In September 2019, a consensus paper was updated by the MS Coalition that discusses the use of disease-modifying therapies in MS.[2] Many options from various disease classes, involving different mechanisms of action and modes of administration, have shown benefits in patients with MS. In addition, practice guidelines for disease-modifying therapies for adults with MS were published by the American Academy of Neurology in 2018.[3] It is noted that many disease-modifying therapies are available and have demonstrated efficacy for the prevention of clinical relapses and new magnetic resonance imaging (MRI)-detected lesions. A lack of response is difficult to define, as most patients with MS are not free of all disease activity. It is recommended clinicians evaluate various factors, such as clinical relapses, new MRI-detected lesions, or increased disability on examination, over a 1-year period of using a disease-modifying therapy.

Coverage Policy

Policy Statement
Prior Authorization is required for benefit coverage of teriflunomide. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with teriflunomide as well as the monitoring required for adverse events and long-term efficacy, approval requires teriflunomide to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Teriflunomide (Aubagio and generic) is considered medically necessary when the following are met:

FDA-Approved Indication

1. **Multiple Sclerosis.** Approve for 1 year if the patient meets ONE of the following (A or B).
   - **A)** Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient has a relapsing form of multiple sclerosis; AND
       Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease.
     - **ii.** Patient is ≥ 18 years of age; AND
     - **iii.** The medication is prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis; AND
     - **iv.** Preferred product criteria is met for the product(s) as listed in the below table(s); OR
   - **B)** Patient is Currently Receiving Teriflunomide for ≥ 1 Year. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
     Note: A patient who has received < 1 year of therapy or who is restarting therapy with teriflunomide should be considered under criterion 1A (Multiple Sclerosis, Initial Therapy).
     - **i.** Patient has a relapsing form of multiple sclerosis; AND
       Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease.
     - **ii.** Patient is ≥ 18 years of age; AND
     - **iii.** Patient meets one of the following (a or b):

a) Patient experienced a beneficial clinical response when assessed by at least one objective measure; OR
Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the Fatigue Symptom and Impact Questionnaire-Relapsing Multiple Sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12-Item Multiple Sclerosis Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss.

b) Patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation; AND

iv. The medication is prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.

Individual and Family Plans:

Product	Criteria
Aubagio (teriflunomide)	The patient has tried the bioequivalent generic product **teriflunomide tablets** [requires prior authorization] AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.

Conditions Not Covered

Teriflunomide (Aubagio and generic) for any other use is considered not medically necessary including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concurrent Use with Other Disease-Modifying Agents Used for Multiple Sclerosis.** These agents are not indicated for use in combination (See Appendix for examples). Additional data are required to determine if use of disease-modifying multiple sclerosis agents in combination is safe and provides added efficacy.

2. **Non-Relapsing Forms of Multiple Sclerosis.** The efficacy of teriflunomide has not been established in patients with non-relapsing forms of multiple sclerosis.[1]
Note: An example of a non-relapsing form of multiple sclerosis is primary progressive multiple sclerosis.

References

1. Aubagio® tablets [prescribing information]. Cambridge, MA: Genzyme/Sanofi; February 2026.
2. A Consensus Paper by the Multiple Sclerosis Coalition. The use of disease-modifying therapies in multiple sclerosis. September 2019.
3. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis. Report of the guideline

development, dissemination, and implementation subcommittee of the American Academy of Neurology. *Neurology*. 2018;90:777-788.

Revision Details

Summary of Changes	Review Date	Effective Date
Added a definition for documentation. **Added** a specialist prescribing requirement. **Added** criteria for patient Currently Receiving Teriflunomide for ≥ 1 Year. **Updated** the preferred product multi-source brand language to current standards. Ocrevus Zunovo was added to the Appendix.	10/24/2024	12/01/2024
The Policy name was changed to add "Oral - Other". **Added** a policy statement. **Removed** documentation requirements. **Updated** the preferred product criteria. **Updated** the conditions not covered statement. **Removed** Extavia from the Appendix.	9/11/2025	11/01/2025
Updated the preferred product requirement. In the Appendix, it was noted that Mavenclad is available as a generic. Also, Tysabri and Tyruko are now cited in the Appendix as follows: Natalizumab Intravenous Products (Tysabri, biosimilar).	2/5/2026	04/01/2026
Multiple Sclerosis: A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway.	8/13/2026	9/15/2026

The policy effective date is in force until updated or retired.

APPENDIX

Medication	Mode of Administration
Aubagio® (teriflunomide tablets, generic)	Oral
Avonex® (interferon beta-1a intramuscular injection)	Injection (self-administered)
Bafiertam® (monomethyl fumarate delayed-release capsules)	Oral
Betaseron® (interferon beta-1b subcutaneous injection)	Injection (self-administered)
Briumvi® (ublituximab-xiiy intravenous infusion)	Intravenous infusion
Copaxone® (glatiramer acetate subcutaneous injection, generic)	Injection (self-administered)
Gilenya® (fingolimod capsules, generic)	Oral
Glatopa® (glatiramer acetate subcutaneous injection)	Injection (self-administered)
Kesimpta® (ofatumumab subcutaneous injection)	Injection (self-administered)
Lemtrada® (alemtuzumab intravenous infusion)	Intravenous infusion
Mavenclad® (cladribine tablets, generic)	Oral
Mayzent® (siponimod tablets)	Oral
Natalizumab Intravenous Products (Tysabri, biosimilar)	Intravenous infusion
Ocrevus® (ocrelizumab intravenous infusion)	Intravenous infusion
Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq subcutaneous injection)	Subcutaneous Injection (not self-administered)
Plegridy® (peginterferon beta-1a subcutaneous or intramuscular injection)	Injection (self-administered)
Ponvory® (ponesimod tablets)	Oral
Rebif® (interferon beta-1a subcutaneous injection)	Injection (self-administered)
Tascenso ODT® (fingolimod orally disintegrating tablets)	Oral
Tecfidera® (dimethyl fumarate delayed-release capsules, generic)	Oral
Vumerity® (diroximel fumarate delayed-release capsules)	Oral
Zeposia® (ozanimod capsules)	Oral

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