PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 11/2014
VERIFIED: 1/2022
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Aubagio

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Aubagio.

Brand Name (select from list of drugs shown)

Aubagio (teriflunomide)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Does the patient have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, active secondary progressive MS)? [If yes, no further questions.]	Yes	No
2	Is the requested drug being prescribed for clinically isolated syndrome?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date