

CRITERIA FOR PRIOR AUTHORIZATION

Tecfidera® (dimethyl fumarate)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Dimethyl fumarate (Tecfidera®)

CRITERIA FOR APPROVAL (must meet all of the following):

- Patient must have a diagnosis of multiple sclerosis
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with a neurologist
 - Prescriber must monitor CBC with differential at baseline and every six months (or earlier if clinically indicated). Absolute lymphocyte count should not be less than 500.
- Dose must not exceed 2 capsules per day

LENGTH OF APPROVAL: 12 months

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

DATE