WEST VIRGINIA Department of Health & Human Resources
Bureau for Medical Services

Office of Pharmacy Service
Prior Authorization Criteria

Tecfidera®
(dimethyl fumarate)

Requests for prior authorization of Tecfidera® will be authorized if the following criteria are met:

1. Diagnosis of relapsing multiple sclerosis
2. Trial of one first line injectable agent, such as interferon β-1a, interferon β-1b or glatiramer
3. Complete blood count (CBC) within six (6) months of initiation of therapy and six months after initiation
4. Complete blood count (CBC) annually during therapy

PL Detail-Document, New Drug: Tecfidera (Dimethyl Fumarate). Pharmacist's Letter/Prescriber's Letter. May 2013.