Special Annual Meeting Programs Focus on Building Leadership Skills

Do you aspire to be a mentor for young neurologists? Would you like to learn how you can be an advocate for your profession and the future of neurology? Do you hope to guide or inspire others in the field of neurology? If so, you’ll first need to cultivate the appropriate skills to be an effective leader—and four special programs, taking place at the 2016 Annual Meeting, are designed to do just that. Space is limited, and pre-registration is required. Visit AAN.com/view/AM16Leader today.

Choose the program that’s right for you:

**C5 Women in Leadership**
Friday, April 15, 9:00 a.m.–5:00 p.m.

**Directors:** Cynthia L. Comella, MD, FAAN, Chicago, IL, and Barbara L. Hoese, Penticore Coaching, Minneapolis, MN

Although women make up 50 percent of physicians and trainees in neurology, they remain underrepresented in the top leadership positions in academic medical centers or large private practices. The AAN is offering this course to support women who are mid-career and currently in a leadership role who have a desire to grow their current leadership.

**2016 Medicare Fees: How AAN Advocacy Works for You**

The release of the 2016 Medicare Physician Fee Schedule (MPFS) final rule yielded positive changes for neurology. For the first time, neurologists may now be reimbursed by Medicare for advance care planning discussions with patients. This comes on the heels of a vigorous advocacy campaign by the AAN and coalition stakeholders. The AAN has long

**Improve Your Coding, Ensure Your Bottom Line—and Enjoy Lower Pricing!**

The New Year brings lower prices for the AAN’s popular series of practice management webinars. This month, you can ensure your practice’s health with this up-to-date review of the best practices in coding for neurodiagnostic procedures such as EMG/NCS and EEG.

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ABPN MOC Clinical Advisory Committee

The American Board of Psychiatry and Neurology has formed a new MOC Clinical Advisory Committee. The AAN had advocated for increased representation of solo and small group practicing neurologists in ABPN decisions about the impact of and future of MOC. Serving on the committee are AAN members Charlene Gamaldo, MD, FAAN; Elaine C. Jones, MD, FAAN; Eddie L. Patton, MD, MS; and Michael Rosenbloom, MD.
President’s Column

Why Should You Come to This Year’s AAN Annual Meeting?

I announced in my September column some exciting changes to our upcoming Annual Meeting in Vancouver from Friday, April 15, to Thursday, April 21. Not only is this our first gathering in this historic Pacific seaport in British Columbia, Canada, it will be the site for many other “firsts” we think you will value and enjoy, and set this Annual Meeting apart from others you have experienced.

Stefan M. Pulst, MD, FAAN, is chair of the AAN’s Meeting Management Committee, which works with our staff on planning our great education and scientific meetings. I’ve invited him to answer some of the questions you might have about the meeting and what we have to offer you in April.

Why should AAN members attend this Annual Meeting?

“The 2016 Annual Meeting will have a greatly changed format to include science every day, two-hour course schedules, and experiential learning at every turn. Our pricing structure has changes as well with a single fee giving attendees access to most everything and most courses without separate fees.”

Tell us about the changes to the schedule.

“You will be able to experience cutting-edge research every day of the meeting. At previous meetings commencing on a Saturday, the Scientific Program didn’t begin until a few days later. For the 2016 Annual Meeting, we have reformatted the schedule so that education sessions AND scientific sessions will take place each day. So no matter what your schedule—whether you come for two days or stay for all seven—you will get a similar experience.”

What are some of the highlights of this year’s Scientific Program?

“I’m pleased to share that, once again, the AAN received a record number of abstract submissions this year—more than 3,000. So, you can expect great exposure for your work and diversity of research expertise at the poster and platform sessions. New this year, the poster halls will remain open all day. The plenary sessions will take place every day with no conflicting courses.”

What are some of the highlights of this year’s Education Program?

“Customization. We now offer most courses in two-hour increments. This allows attendees to sample a wider variety of programs. Most courses also are now included with your registration and do not require a separate fee.”

How does the new single registration rate work?

“Many attendees have asked for this change. Your one, low registration price now offers access to most of the Annual Meeting’s 230+ education courses as well as the Scientific Program. One low price allows attendees to sample a wider variety of programs, and greater flexibility to customize their schedule more easily on-site.”

Continued on page 7 ➤
Elaine C. Jones, MD, FAAN

This is part of a series of profiles of members of the Board of Directors for the AAN and AAN Institute.

Elaine C. Jones, MD, FAAN, a general neurologist in solo, private practice in Bristol, RI, since 2005, joined the AAN Board in April after completing a term as an ex officio member of the Board of Directors as chair of the Government Relations Committee. A graduate of the Palatucci Advocacy Leadership Forum and frequent participant in the Neurology on the Hill advocacy event, Jones has served on several AAN committees, including the Medical Economics and Management Committee and the Payment Policy Subcommittee, which she currently chairs. Jones has served as president of the Rhode Island Medical Society and on many state task forces.

Meet Your Leader

What moved you to join the Board of Directors?

My prior experiences within the Academy on committees and work groups have led me to realize what a strong organization the AAN really is. At the same time, I am never one to sit back and complain about how things are going. I always jump in with both feet and try to help change things. The Academy allows someone like me to get involved and have a voice. I am not a high-powered academician or researcher. I am not, nor ever will be, famous as a neurologist. But even someone like me in a solo practice, simply seeing patients to make a living, is encouraged to get involved with the largest organization representing neurologists. To me this speaks volumes about the Academy, and it is an organization I want to be involved with.

What experiences and viewpoints do you bring to this role?

I am a solo, private practitioner, and we are a different breed of neurologist from the academics or the large practices. We have different struggles and stresses in our practices. As health care changes dramatically, and the AAN responds to help all members, it is important to have voices from different regions, practice types, gender and age groups. I am from the northeastern US, but the smallest state in the union. I am a female neurologist in mid-career. I spent some time working in the political arena for the AAN so I understand the legislative world. I have learned how to be an advocate for my patients and my profession, and how to encourage others to do the same.

From your experiences as an AAN leader, what is one of the more common misperceptions members may have about the Academy?

The one I hear all the time has to do with “town-gown” politics. I hear the AAN is only representing academic centers and doesn’t understand the little practices or the private practices. While this may have been true in the past, it is clearly something the Academy has taken to heart and focused on changing. All committees and all levels of leadership have small and solo private practices represented now. I would ask those who perpetuate this complaint to look into the facts currently, and then to consider getting involved. The Academy is welcoming to these members and searching for more to get involved.

In your view, how does the AAN benefit the field of neurology most?

Clearly the biggest thing the Academy does is to provide outstanding educational opportunities to members. The resources available to keep us up-to-date on scientific and practice advances is outstanding. And so many of these resources are free to members. This allows us to provide the highest quality care to our patients. What’s better than that?

How should members evaluate the success of the AAN and the board in supporting their careers and neurology in general?

When you are down in the weeds and getting overwhelmed by all the bureaucracy that we have to deal with these days, it is hard to step out and see the bigger picture. And the obvious scapegoats are the organizations that we expect to fight for us. If our lives are hard, it is because the Academy didn’t fix it. It is up to us to fix it and it is up to the Academy to help us do that. The AAN’s vision is to be indispensable to its members. It isn’t to make our practices more financially successful. Or even to make neurology patients healthier. The Academy should be measured on how it supports you in what you need to do. What resources are they providing to keep you up-to-date on treatments and testing? What tools are they providing to help you run your practice successfully? What gaps are they missing and not helping you deal with? But none of us should live in a vacuum and expect them to fix our problems for us. We have to work together to continue to make neurology the viable and exciting field that we went into.

How do you deal with the challenges of balancing the demands of your work and personal life?

Some days I do this better than others. I have learned to say “no” more lately. I look for things that are enjoyable and make sure I do them—once a day (going for a run), once a week (playing golf or sailing), once a month (getting a pedicure). I start each year by scheduling my vacation time. I did this after I realized I hadn’t taken an actual vacation in two years. I schedule downtime and fun time into my calendar. I have learned that if I don’t pay attention to it, it doesn’t take care of itself.

For more information on Jones and other AAN leaders, visit AAN.com/membership/board-of-directors.
What’s New at the 2016 Annual Meeting?

No More Course Fees!*
One low registration price now gets you access to most of the AAN’s 230+ education courses, with no pre-registration for individual courses required. Registration is your ticket to most everything the Annual Meeting has to offer—all week long and at no additional cost to you.

Stress-Free Scheduling!
Sample a wider variety of programs than ever before! Education courses will now take place in 2-hour increments. Poster sessions will begin on Saturday and run through Thursday. And plenary sessions will take place every day with no conflicting courses.

Innovative Research Every Day!
The popular Scientific Program includes a variety of sessions covering hot topics, critical issues, and latest scientific highlights in addition to an anticipated 2,700+ cutting-edge abstracts presented in poster and platform sessions throughout the week.

Experiential Learning!
Everyone has a different learning style, and the state-of-the-art Vancouver Convention Centre—host to major events such as the 2010 Winter Olympics and acclaimed TED conference—will allow us to deliver innovative and exciting content like never before with dynamic and interactive learning areas available all week long.

The Days!
While previous Annual Meetings have traditionally run Saturday through Saturday, the 2016 meeting will begin on a Friday and end on a Thursday. This new, condensed timeframe creates opportunities for exciting changes while still allowing you to completely customize your schedule to your interests and needs.

REGISTER TODAY! AAN.com/view/AM16

*Skills Workshops, Maintenance of Certification Exam Preparation Course, Between Venus and Mars: How Great Leadership Adopts Traits from the Best of Both Genders, Improving Your Leadership Skills: A Practical Approach, Women in Leadership, Research Career Development Symposium, The Most Important Tool in Your Black Bag: Gallup StrengthsFinder™ Assessment I & II, Continuum® Test Your Knowledge: A Multiple-choice Question Review I & II, Genomic Neurology Workshop: Developing Practical Knowledge of Tools and Concepts Through Case Studies I & II, and Bedside Evidence-based Medicine: How to Find and Deconstruct Articles in Order to Take Care of Patients I & II are not included in the Annual Meeting Registration price. These courses require pre-registration, may have a separate registration fee, and are subject to closure due to reaching maximum capacity.
capacity and learn from successful female members in the field of neurology about how to lead at senior levels. This program is supported in part by Allergan, Inc.

C82 Between Mars and Venus: How Great Leadership Adopts Traits from the Best of Both Genders
Sunday, April 17, 1:00 p.m.–5:00 p.m.
Directors: Orly Avitzur, MD, MBA, FAAN, Tarrytown, NY; Stefan M. Pult, MD, FAAN, Salt Lake City, UT; and Barbara L. Hoese, Penticore Coaching, Minneapolis, MN

Recent research on leadership in the labor force asserts that the most successful organizations are the ones that make an effort to place both men and women in key leadership positions. This course provides participants with an opportunity to understand differences in style, mindset, and communication between men and women, and learn practical ideas and approaches to eliminate gender discrimination and lead together in “gender-neutral” workplaces. This program is supported in part by Novartis Pharmaceuticals Corporation.

C115 Improving Your Leadership Skills: A Practical Approach
Monday, April 18, 1:00 p.m.–5:00 p.m.
Directors: Terrence L. Cascino, MD, FAAN, Rochester, MN, and Ralph L. Sacco, MD, MS, FAHA, FAAN, Miami, FL

Leadership has been defined as having a sound vision and convincing others to follow you. This course will assist participants in implementing the vision and offer practical tips and case examples on how to persuade others to follow. Upon completion, participants will be better equipped to apply knowledge to their leadership roles in the hospital, community, state medical society, professional organization and political action.

C233 and C234 The Most Important Tool in Your Black Bag: Gallup StrengthsFinder™ Assessment
Tuesday, April 19, and Wednesday, April 20, 1:00 p.m.–5:00 p.m.
Directors: Keri Bischoff and Julie Anderson, Anderson & Bischoff Strengths Consulting, St. Paul, MN

A leader needs to know his/her strengths as a carpenter knows his/her tools, or a physician knows the instruments at his/her disposal. In this customized half-day workshop, two Gallup Certified consultants will share a language for understanding your unique strengths, which has powerful application for well-being and happiness. Discover your top five talent themes, and learn ways that the Gallup StrengthsFinder Assessment can change the culture of your organization through engagement, which leads to increased productivity, patient satisfaction, and peer understanding. •
Abstract Authors to Receive Notification Next Month

Authors who submitted abstracts for the 2016 Annual Meeting will be notified by email in early February whether their abstract was accepted for the Scientific Program. For more information, email science@aan.com or call (612) 928-6088.

President’s Column

Why Should You Come to This Year’s AAN Annual Meeting?  

Continued from page 3

What kind of savings can members expect? Is everything included in the new single registration rate?

“We are confident members will see significant value in this new structure compared to the prior pay-per-course pricing model. Now, everything is included with only a few exceptions. Certain Skills Workshops, Leadership programs, and a few other courses will still require a separate fee and advance registration as they have limited seating. These courses are noted as ‘Special Programs’ when you register. And we will still offer our Annual Meeting On Demand, the virtual multi-media library of the meeting, for an upgraded rate.”

If most everything is included, how do attendees select their education courses? Must they do so in advance?

“No. With the exception of the previously mentioned ‘Special Programs’ that require pre-registration, attendees can simply show up at the room to attend courses of interest (be aware that you MUST complete your course evaluation to qualify for CME). If you prefer to pre-plan, an Itinerary Planner is available within the registration site at AAN.com/view/register that will allow you to browse courses and plan your schedule of events during the meeting. A conference mobile app will be available in January to download for easy planning on-the-go. All rooms will have a maximum number of attendees that will be accommodated, so plan to arrive early to the courses you wish to attend.”

What other enhancements can attendees expect?

“Each of us has a different or preferred style of learning. Many enjoy the didactic tradition of the classroom lecture or public address. Others find great benefits in poster sessions, intently absorbing knowledge at their own pace. Some, however, find interactive, hands-on learning more engaging. We are taking advantage of the state-of-the-art Vancouver Convention Centre, which hosted events during the 2010 Olympics as well as the acclaimed TED Conference, to deliver innovative content in the new Experiential Learning areas during the entire meeting.

“We have also kept most evenings clear of meeting activities to leave time for networking and opportunities to connect with colleagues and friends and to enjoy the richness of downtown Vancouver nightlife.”

Those of you who have attended past meetings will welcome the streamlined program and enjoy the exciting city of Vancouver. And for those of you who have not yet attended an AAN Annual Meeting, I guarantee this will be a marvelous introduction to the vitality of our profession and the importance of our contributions to the science of neurology and the care of our patients.

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology
tcascino@aan.com
Power Your Practice: Understand Your Alternative Payment Options

According to the latest AAN Neurology Compensation and Productivity Survey, 25 percent of neurologists were working in an accountable care organization (ACO) in 2014. A much smaller number participated in bundled payments (5 percent) or a patient-centered medical home (8 percent). It may be reasonable to expect these numbers have risen over the past year, with both CMS and commercial insurers moving toward more payments coming from value-based payments and other alternative payment models.

Yet many neurologists who are part of an ACO have little understanding of what that means for them or feel it has no impact on the way they practice or get paid. Many other neurologists may wonder if they should participate in an alternative payment model (APM). Depending on your geography and practice type, the range of available APMs for neurologists will vary. Neurologists may be able to integrate with other practices or form a patient-centered specialty practice focused on a neurologic disease, such as MS or ALS.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new committee within the Government Accountability Office that will review proposals for new APMs, so you can expect more alternative payment options to be available in the coming years. The AAN is beginning work on developing an APM option that would be relevant for private neurologists in small practices.

MACRA Participant Eligibility Requirements for APM

Physicians must receive at least 25 percent of their revenue in qualified APMs. That percentage of payment increases over the years to 50 percent, and eventually 75 percent of payments. Payments coming from APMs through commercial insurers also can be counted toward that total beginning in 2021. MACRA also requires that APMs must use a certified electronic health record (EHR), use quality measures, and bear financial risk.

APM Bonus Payments

Physicians who meet the qualifications will get an automatic 5-percent lump sum bonus payment on all of their Medicare professional services, not just for the care provided to the APM patients. The bonus payment is on top of any extra payments they receive through the APM, such as shared savings or per member per month payments. Physicians also will be exempt from the Merit-based Incentive Payment System (MIPS) program that begins in 2019 and not subject to those program penalties.

However, one should keep in mind the bonus goes to the APM entity, so it’s possible that individuals participating in the APM may not see the full 5-percent bonus depending on contract terms. Nonetheless, the individual neurologist still would be exempt from MIPS, so that’s positive.

The AAN is aware that the existing APM options favor primary care providers. For several years, the Academy has stressed in meetings with CMS the need to develop more specialty options. The AAN is optimistic that this dialogue eventually will bring about the changes that provide more fairness to specialists such as neurologists.

Is an APM Right for You?


Neurology WriteClick®:
Join the Discussion!

Comment on Neurology® journal articles and read what others are saying at Neurology.org.
advocated for this coverage and participated in defining these codes. Other changes in the MPFS will also impact neurology and underscore the importance of continuing to build deeper relationships with federal regulators.

Discussions with patients and their families about end-of-life concerns are among the most challenging parts of a neurologist’s day. These conversations require an extra measure of clarity, patience, and compassion—as well as time—that, until now, was not reimbursed by the Centers for Medicare & Medicaid Services (CMS).

The advance care planning decision offers access to voluntary services under Medicare and provides individuals with an important opportunity to establish and document their preferences and goals of care. Medicare now will pay a physician’s office approximately $86 for the first 30 minutes of advance care planning. Furthermore, Medicare will pay approximately $75 for an additional 30 minutes of consultation.

Codes 99497, 99498 are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment. Furthermore, when using codes 99497, 99498, no active management of the problem(s) is undertaken during the time period reported.

While the advance care planning code decision is a good example of how the AAN’s regulatory advocacy efforts have paid off, other parts of the MPFS final rule show the importance of continuous engagement with federal regulators.

In the area of evaluation and management (E/M) services, the AAN has been a leader in efforts calling for additional CMS research. The agency showed interest in this effort by proposing a number of E/M-related questions in its July proposed MPFS rule. The AAN is pleased to see CMS’s interest in ways to recognize the different resources in cognitive work involved in the delivery of broad-based, ongoing treatment. Though CMS did not announce policy changes for E/M activities in this year’s final rule, the agency said it will be considering proposals for next year’s MPFS.

The AAN will continue to advocate for codes that allow for the reporting of the additional time and intensity of the cognitive work undertaken by neurologists in conjunction with an E/M service. The Academy also will keep pushing for improvements to the accuracy of payments for care coordination, especially for patients requiring more complex care. Similarly, although

CMS did not finalize any proposals regarding the global surgical package, the AAN will continue to support efforts to accurately capture the work associated with these service periods. CMS intends to issue proposals next year, underscoring the importance of continued AAN efforts with the agency.

The 1,358 pages in the rule cover a wide array of Medicare policy decisions. Other areas affecting neurology include the CMS decision, called for by the AAN, to hold off on implementing “appropriate use criteria” that will eventually require physicians to consult clinical decision support software about the necessity of certain services before providing them. CMS further noted it will use calendar year 2016 as the performance period for the calendar year 2018 value modifier and continue to apply the 2018 value modifier based on participation in the PQRS by groups and solo practitioners. The 2016 performance period also is expanding, now including non-physician eligible professional solo practitioners and group practices, such as physician assistants, nurse practitioners, and clinical nurse specialists.

“Over the past year,” said Orly Avitzur, MD, MBA, FAAN, chair of the Medical Economic and Management Committee, “the AAN has worked hard to develop a more meaningful relationship with CMS, holding several meetings with agency officials and actively commenting on regulatory proposals like the MPFS. Developing a proactive regulatory advocacy program is important because these efforts help shape the regulations that impact neurology practices across the country. As evident in this year’s MPFS, there is much work left to be done. The regulatory landscape keeps on changing, and you can rest assured that the AAN will be there every step of the way to advocate on behalf of your interests.” •

*Continued from cover

AAN members and staff analyzed the 1,300+ pages in the new MPFS rule to ensure members are aware of changes that will affect their practices.
Break the Code, or It Will Break Your Practice—Coding for Neurodiagnostic Procedures

January 12, 2016, from 12:00 p.m.–1:00 p.m. ET

Deadline to Register: January 11

Director: Neil Busis, MD, FAAN

Learn to code appropriately for neurodiagnostic procedures including EMG and nerve conduction studies, and EEG procedure

Use code modifiers appropriately

Understand use of Appendix J in counting the appropriate number of studies used to diagnose common neuromuscular conditions

Avoid common coding errors

New 2016 Member Pricing!

AAN members benefit from reduced pricing in 2016: only $99 per webinar (save $50 each from 2015 fee) or subscribe to the complete 2016 webinar series for only $189 (save $10 from 2015 subscription).

New and convenient one-hour sessions

Physicians will earn 1 AMA PRA Category 1 Credit™ per webinar and non-physicians will receive a certificate of completion

Includes presentation slides and access to recording

To initiate a 2016 subscription, simply start registering for a single webinar and the option to subscribe to all 10 live webinars will be presented. The 2016 subscription offer does not include registration for webinars presented in 2015, which must be made in a separate transaction. Learn more and register at AAN.com/view/pmwm16.

Get Your Best Value and Subscribe to ALL 2016 Practice Management Webinars

January 12  Break the Code, or It Will Break Your Practice—Coding for Neurodiagnostic Procedures

February 9  What Is MACRA?—Critical Preparation for CMS Reimbursement

March 8  Get Caught Up: The ICD-10-CM Crosswalk Is Now a Cross-run

March 22  Documentation into Dollars: Evaluation/Management

May 11  Merit, Incentives, Use, and Quality: The Alphabet Soup of Value-based Care

June 14  Better at Getting Better: A Neurology Guide to Quality Improvement

August 10  Grading on a Curve: Using Benchmarks to Improve Your Bottom Line

September 13  Solo, But Not Alone: Thriving in Small Neurology Practices

October 11  Don’t Just Phone It In: A Guide to Teleneurology

November 8  Getting the Most Out of Your Technology: HIT and Your Patients

February 9:
Learn How MACRA Will Affect You

Set aside an hour on February 9, from 12:00 p.m. to 1:00 p.m. ET, for “What Is MACRA?—Critical Preparation for CMS Reimbursement.” Learn how this legislation overhauling the CMS payment system will impact your practice, changing it from fee-for-service to pay-for-performance.
Podcast Central
Your Guide to New and Recent AAN Podcasts

Neurology® Podcasts
Visit Neurology.org to listen to Neurology podcasts and earn 0.5 AMA PRA Category 1 CME Credits™ by answering the multiple-choice questions in the online podcast quiz.
Important Note: Interviews based on articles from Neurology® Clinical Practice, Neurology® Genetics, and Neurology® Neuroimmunology & Neuroinflammation are excluded from the CME program.

Available by January 1
- **Neurology**: Endovascular versus medical management of acute ischemic stroke
  Kevin M. Barrett, MD, MSc, and Bradford B. Worrall, MD, MSc, FAAN
- **Neurology**: Practice guideline: Idiopathic normal pressure hydrocephalus: Response to shunting and predictors of response
  Farrah J. Mateen, MD, PhD, and John J. Halperin, MD, FAAN
- **Neurology**: Neuroimmunology & Neuroinflammation: Basal ganglia T1-hyperintensity in LGI1-autoantibody faciobrachial dystonic seizures
  Jeff Waugh, MD, PhD, and Eoin P. Flanagan, MB, BCh, MD

Public Policy

Capitol Hill Report
Capitol Hill Report presents regular updates on legislative and regulatory actions and how the Academy ensures that the voice of neurology is heard on Capitol Hill. It is emailed to US members twice monthly and is posted at AAN.com/view/HillReport. Below are some recent highlights.

Mike Amery attended the 50th anniversary meeting of the Indiana State Neurosociety with AAN Board Members James Stevens, MD, FAAN, and Thomas Vidic, MD, FAAN, both of whom have been involved in the long-term success of the Indiana society. State Chair Ann Hake, MD, pulled out all the stops with a meeting at the Conrad Hilton in the heart of Indianapolis followed by a dinner at the Rathskeller—the very place the society founders used for their initial meetings in 1965.

Amery gave a federal update to the 85 attendees and urged them to stop by the AAN table in the exhibit hall to cast a vote in a presidential straw poll—which produced a tie between Dr. Ben Carson (R) and former Secretary of State Hillary Clinton (D) leading the way for their parties.

The AAN believes that state neurosocieties are vital to strengthening the profession of neurology and we are committed to supporting state-based efforts. Learn more about your state society at AAN.com/membership/state-societies.
Epilepsy Issues Covered in Audio Series

Epilepsy emergencies, nonepileptic seizures, and management of a first seizure are among the issues covered in the latest Continuum® Audio series. Listen during your commute or your workout to stay up-to-date on the latest information on epilepsy with the experts.

“This series provides updates on diagnosis and management by age groups and epilepsy types and explores challenges unique to patient subgroups such as women and those with comorbid conditions,” said David C. Anderson, MD, FAAN, host of the series and associate editor for Continuum Audio.

The first two hours of the series are available this month; the second two hours will be available in February.

Hour 1:
- Gregory D. Cascino, MD, FAAN Diagnosis of Epilepsy and Related Episodic Disorders
- Elaine Wirrell, MD Infantile, Childhood, and Adolescent Epilepsies
- Christopher T. Skidmore, MD Adult Focal Epilepsies

Hour 2:
- Ajay Gupta, MD Febrile Seizures
- Nicolas Gaspard, MD, PhD Autoimmune Epilepsy
- W. Curt La France, Jr., MD, MPH, FAAN, FANPA, DFAPA Diagnosis and Treatment of Nonepileptic Seizures

Hour 3:
- Gregory K. Bergey, MD, FAAN Management of a First Seizure
- Bassel W. Abou-Khalil, MD, FAAN Antiepileptic Drugs
- Dileep R. Nair, MD Management of Drug-resistant Epilepsy
- Joseph I. Sirven, MD, FAAN Management of Epilepsy Comorbidities

Hour 4:
- Stephen Hantus, MD Epilepsy Emergencies
- Elizabeth E. Gerard, MD Managing Epilepsy in Women
- Chad Carlson, MD Special Issues in Epilepsy: the Elderly, the Immunocompromised, and Bone Health
- Georgia Montouris, MD Cultural Barriers to Medication Adherence in Epilepsy

Continuum Audio is an audio CME program based on discussions with the authors of articles published in Continuum: Lifelong Learning in Neurology®, the official CME journal of the AAN. Continuum Audio is available in multiple formats, including apps for iOS and Android devices. This program may be used to meet self-assessment and CME requirements for maintenance of certification as mandated by the American Board of Psychiatry and Neurology. To learn more and subscribe, visit Audio-digest.org/Continuum.

UCNS Headache Medicine Certification, Recertification Exam Applications Available

Applications are now available for initial certification and recertification in Headache Medicine from the United Council for Neurologic Subspecialties. The deadline to apply for the exams is April 15, 2016, and both will be offered the week of October 17 through 21, 2016.

Because UCNS offers examinations once every two years, all those certified in Headache Medicine in 2006 or 2007 must apply to take the 2016 recertification exam to maintain their certification.

For eligibility requirements and to apply, visit UCNS.org/go/subspecialty/headache/certification. For more information, contact Todd Bulson at tbulson@ucns.org or (612) 928-6067.
Józefowicz to Receive President’s Award

Ralph F. Józefowicz, MD, FAAN, will receive the 2016 AAN President’s Award at the Presidential Plenary Session at the Annual Meeting in Vancouver. He is professor of neurology and medicine, associate chair for education in the department of neurology, and neurology residency program director at the University of Rochester in New York.

“It is my honor to name Dr. Ralph Józefowicz as the recipient of the 2016 President’s Award,” said AAN President Terrence L. Cascino, MD, FAAN. “He is considered by many of his peers and students to be the consummate neurological educator over the past two decades. His accomplishments at the University of Rochester are legendary as clinician educator and program director. It is not a coincidence that this medical school averages 10 percent of its students entering neurology per year.

“Nationally, Dr. Józefowicz has been a leader with the National Board of Medical Examiners, Neurology Residency Review Committee, and American Board of Psychiatry and Neurology. While his contributions have produced meaningful improvements in neurological education, this award is primarily given for his dedication as an AAN member. Dr. Józefowicz has given unselfishly in his numerous roles as an AAN volunteer, including chair of the Undergraduate Education Committee, chair of the Education Committee, member of the Board of Directors, treasurer of the American Brain Foundation, and numerous other roles behind the scenes. His duties always have been accomplished with great enthusiasm and always putting the profession and students at the forefront. For all his unselfish work to better our profession, Dr. Ralph Józefowicz is a most deserving awardee.”

Józefowicz has been an AAN member since 1983. He currently chairs the Joint Investment Committee and is a member of Meeting Management Committee, Member Engagement Committee, and the A.B. Baker Section of Neurologic Educators. Other leadership positions have been on the International Education Subcommittee, Committee on Sections, Annual Meeting Subcommittee, Continuum® Editorial Board Subcommittee, and Academic Task Force.

His numerous past honors include the AAN’s Consortium of Neurology Program Directors Recognition Award, the A.B. Baker Lifetime Achievement Award for Neurologic Education, and the American Brain Foundation Chair’s Award.

Look for Neurology Today’s ‘Best Advances of 2015’ in January 7 Issue

Stroke neurologists face a clinical conundrum these days. The use of oral anticoagulants (OACs) is increasing, but there is a dearth of data on how to treat intracerebral hemorrhage associated with OACs.

This is why Neurology Today® Editorial Advisory Board Member Kevin Sheth, MD, FAAN, FAHA, an associate professor of neurology and of neurosurgery and chief of the division of neurocritical care and emergency neurology at Yale University, cited a trial on this topic as one of the most noteworthy developments in 2015.

“Most of the attention in the stroke community has been on the new clot retrieval devices, but this paper is important because it sets the stage for a clinical trial that is urgently needed to answer whether or not we should anticoagulate people with intracerebral hemorrhage and atrial fibrillation.”

To learn more about this study and other critical developments in neurology this past year, read “The Best Advances of 2015” feature in the January 7, 2016, issue of Neurology Today.

“Every year, we ask our editorial advisory board members to scan the literature in their specialties and report back on what they think are the most important developments in the field,” said Neurology Today Editor-in-Chief Steven P. Ringel, MD, FAAN.

“Through our annual ‘Best Advances’ feature, our experts tell us what is worth our attention, and why. Their selections cover a wide range of areas—from dementia, multiple sclerosis, traumatic brain injury, epilepsy, movement disorders, concussion, stroke, pain, neurogenetics, neuropathy, and child neurology—to neuroethics, healthy policy, and professionalism issues.”

For the latest coverage from Neurology Today, the official news source of the AAN, visit NeuroTodayOnline.com.
Guidelines

Read Systematic Review on Rehabilitation in MS

The AAN published “Comprehensive Systematic Review Summary: Rehabilitation in Multiple Sclerosis” in the November 24, 2015, print issue of Neurology®.

This new systematic review from the AAN shows that eight weeks of home or outpatient physical therapy can help improve balance, disability, and gait in people with multiple sclerosis (MS). The review also finds that six weeks of comprehensive multidisciplinary outpatient rehabilitation may help function and disability in MS. The authors conclude that there is a need for well-designed studies to substantiate the existing data available regarding MS rehabilitative therapies.

“In addition to the evidence supporting the use of inpatient and outpatient physical therapy for balance, gait, and disability, our review found some evidence for the use of comprehensive multidisciplinary rehabilitation to improve disability, breathing-enhanced upper-extremity exercises to improve gait and respiration measures, and inspiratory muscle training to improve respiration measures, although for many other modalities the need for additional randomized, controlled trials is apparent,” said lead author Jodie Haselkorn, MD, MPH. “We know that more high-quality research is needed with appropriate numbers of participants, blinding, sham treatments, a carefully selected objective primary outcome measure, and meaningful protocols that more fully define the intensity, length of time, functional outcome, and duration of benefit for rehabilitative strategies.”

Read the review and access PDF summaries for clinicians and patients at AAN.com/guidelines. For more information, contact Julie Cox at jcox@aan.com or (612) 928-6069. •

Jodie Haselkorn, MD, MPH

QUALITY.
It’s In Everything You Do.

Quality is at the center of your work. But demonstrating it is how you show your value. Use the AAN’s tools and resources to help you.

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QUIETING MS Quietly*
for your patients with relapsing MS

INDICATION
AUBAGIO® (teriflunomide) is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

IMPORTANT SAFETY INFORMATION
WARNING: HEPATOTOXICITY AND RISK OF TERATOGENICITY
Severe liver injury including fatal liver failure has been reported in patients treated with leflunomide, which is indicated for rheumatoid arthritis. A similar risk would be expected for teriflunomide because recommended doses of teriflunomide and leflunomide result in a similar range of plasma concentrations of teriflunomide. AUBAGIO is contraindicated in patients with severe hepatic impairment and in patients taking leflunomide. Concomitant use of AUBAGIO with other potentially hepatotoxic drugs may increase the risk of severe liver injury. Obtain transaminase and bilirubin levels within 6 months before initiation of AUBAGIO therapy. Monitor ALT levels at least monthly for 6 months after starting AUBAGIO. If drug-induced liver injury is suspected, discontinue AUBAGIO and start an accelerated elimination procedure with cholestyramine or charcoal. Patients with pre-existing liver disease may be at increased risk of developing elevated serum transaminases when taking AUBAGIO.

Based on animal data, AUBAGIO may cause major birth defects if used during pregnancy. Pregnancy must be excluded before starting AUBAGIO. AUBAGIO is contraindicated in pregnant women or women of childbearing potential who are not using reliable contraception. Pregnancy must be avoided during AUBAGIO treatment or prior to the completion of an accelerated elimination procedure after AUBAGIO treatment.

Please see additional Important Safety Information and Brief Summary of Full Prescribing Information, including boxed WARNING regarding hepatotoxicity and use in pregnancy, on the following pages.
AUBAGIO® (teriflunomide) efficacy was established in TEMSO and reinforced with TOWER and TOPIC. Phase III clinical trials

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Warnings and Precautions

Patients with pre-existing acute or chronic liver disease, or those with serum ALT >2 times the upper limit of normal (ULN) before initiating treatment, should not normally be treated with AUBAGIO. In clinical trials, if ALT elevation was >3 times the ULN on 2 consecutive tests, patients discontinued AUBAGIO and underwent accelerated elimination. Consider additional monitoring if co-administering AUBAGIO with other potentially hepatotoxic drugs; monitor patients who develop symptoms suggestive of hepatic dysfunction (e.g., unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine).

Before starting therapy, use of reliable contraception must be confirmed, and the patient counseled on risks to the fetus. Patients with delayed onset of menses or other reason to suspect pregnancy should immediately see their physician for pregnancy testing. Patients who become pregnant or wish to become pregnant should discontinue treatment, followed by accelerated elimination until plasma concentrations of <0.02 mcg/mL are verified, a level expected to pose minimal risk to the fetus. Women who become pregnant while taking AUBAGIO may enroll in the AUBAGIO pregnancy registry by calling 1-800-745-4447, option 2.

Teriflunomide is eliminated slowly from the plasma—it takes an average of 8 months, or up to 2 years, to reach plasma concentrations <0.02 mcg/mL. Elimination may be accelerated by administration of cholestyramine or charcoal, but this may cause disease activity to return in patients who were responding to AUBAGIO.

Decreases in white blood cell counts, mainly of neutrophils and lymphocytes, and platelets have been reported with AUBAGIO. Obtain a complete blood cell
A proven approach to quieting relapsing MS

2 trials impacting disability progression
- AUBAGIO 14 mg is the only oral MS therapy with 2 pivotal Phase III trials that show a significant reduction in the risk of sustained disability accumulation.\(^1,3,4\)
- AUBAGIO 7 mg did not demonstrate a significant reduction in risk of sustained disability progression in either trial.\(^1\)

1 daily tablet
- AUBAGIO is one tablet, once a day.\(^1\)

TEMSO: A double-blind, placebo-controlled trial in patients with relapsing forms of MS (N=1088). Patients were randomized to receive AUBAGIO 14 mg (n=359), AUBAGIO 7 mg (n=366), or placebo (n=363) once daily for 108 weeks.\(^1\)

TOWER: A double-blind, placebo-controlled trial in patients with relapsing forms of MS (N=1169). Patients were randomized to receive AUBAGIO 14 mg (n=372), AUBAGIO 7 mg (n=408), or placebo (n=389) once daily with results for up to 40 months of treatment.\(^1,5\)

TOPIC: A double-blind, placebo-controlled clinical trial in patients with relapsing MS (N=618). Patients were randomized to receive AUBAGIO 14 mg (n=216), AUBAGIO 7 mg (n=205), or placebo (n=197) once daily for 108 weeks. Patients had a first clinical event consistent with acute demyelination occurring within 90 days of randomization with 2 or more T2 lesions at least 3 mm in diameter characteristic of MS.\(^1,6\)

Study 4: A randomized, double-blind, placebo-controlled trial in patients with relapsing forms of MS (N=179). Patients were randomized to receive AUBAGIO 14 mg (n=57), AUBAGIO 7 mg (n=61), or placebo (n=61) once daily for 36 weeks.\(^1\)

Adverse Reactions: The most frequent adverse reactions (≥10% and ≥2% greater than placebo) with AUBAGIO 7 mg and 14 mg and placebo, respectively, were headache (18% and 16% vs 15%), ALT increased (13% and 15% vs 9%), diarrhea (13% and 14% vs 8%), alopecia (10% and 13% vs 5%), and nausea (8% and 11% vs 7%).

Drug Interactions: Monitor patients when teriflunomide is coadministered with warfarin, or with drugs metabolized by CYP1A2, CYP2C8, substrates of OAT3 transporters, substrates of BCRP, or OATP1B1/1B3 transporters.

Use in Specific Populations: AUBAGIO is detected in human semen. To minimize any possible fetal risk, men not wishing to father a child and their female partners should use reliable contraception. Men wishing to father a child should discontinue therapy and undergo accelerated elimination, with verification of plasma concentrations <0.02 mcg/mL. Nursing mothers should not use AUBAGIO.

Please see Brief Summary of Full Prescribing Information, including boxed WARNING regarding hepatotoxicity and use in pregnancy, on the following pages.

Count within 6 months before starting treatment, with further monitoring based on signs and symptoms of bone marrow suppression. AUBAGIO is not recommended for patients with severe immunodeficiency, bone marrow disease, or severe uncontrolled infections. Tuberculosis (TB) has been observed in clinical studies of AUBAGIO. Before starting treatment, screen patients for latent TB infection with a tuberculin test. Treatment in patients with acute or chronic infections should not be started until the infection(s) is resolved. Administration of live vaccines is not recommended. The risk of malignancy, particularly lymphoproliferative disorders, or infection may be increased with the use of some medications with immunosuppressive potential, including teriflunomide. Peripheral neuropathy, including polyneuropathy and mononeuropathy, has been reported with AUBAGIO. Age >60 years, concomitant neurotoxic medications, and diabetes may increase the risk. If peripheral neuropathy is suspected, consider discontinuing treatment and performing accelerated elimination.

Interstitial lung disease and rare cases of Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported with leflunomide; a similar risk would be expected for teriflunomide. If a severe skin reaction develops with AUBAGIO, stop treatment and use accelerated elimination.

Blood pressure increases and hypertension have occurred with AUBAGIO. Measure blood pressure at treatment initiation and manage any elevations during treatment.
AUBAGIO is effective across key measures of disease activity: sustained disability progression (14 mg only), annualized relapse rate, and MRI activity. Common adverse events with AUBAGIO led to treatment discontinuation rates ≤3.3% in the pooled clinical trials.1,2

Please see Important Safety Information on previous pages and Brief Summary of Full Prescribing Information, including boxed WARNING regarding hepatotoxicity and use in pregnancy, on the following pages.

WARNING: HEPATOTOXICITY AND RISK OF TERATOGENICITY

Hepatotoxicity
Severe liver injury including fatal liver failure has been reported in patients treated with leflunomide, which is indicated for rheumatoid arthritis. A similar risk would be expected for teriflunomide because recommended doses of teriflunomide and leflunomide result in a similar range of plasma concentrations of teriflunomide. Concomitant use of AUBAGIO with other potentially hepatotoxic drugs may increase the risk of severe liver injury. Obtain transaminase and bilirubin levels within 6 months before initiation of AUBAGIO therapy. Monitor ALT levels at least monthly for six months after starting AUBAGIO [see Warnings and Precautions (5.1)]. If drug induced liver injury is suspected, discontinue AUBAGIO and start an accelerated elimination procedure with cholesterylamine or charcoal [see Warnings and Precautions (5.3)]. AUBAGIO is contraindicated in patients with severe hepatic impairment [see Contraindications (4.1)]. Patients with pre-existing liver disease may be at increased risk of developing elevated serum transaminases when taking AUBAGIO.

Risk of Teratogenicity
Based on animal data, AUBAGIO may cause major birth defects if used during pregnancy. Pregnancy must be excluded before starting AUBAGIO. AUBAGIO is contraindicated in pregnant women or women of childbearing potential who are not using reliable contraception. Pregnancy testing is recommended prior to starting AUBAGIO treatment or prior to the completion of an accelerated elimination procedure after AUBAGIO treatment [see Contraindications (4.2), Warnings and Precautions (5.2), and Use in Specific Populations (8.1)].

1 INDICATIONS AND USAGE
AUBAGIO® is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

2 DOSAGE AND ADMINISTRATION
The recommended dose of AUBAGIO is 7 mg or 14 mg orally once daily. AUBAGIO can be taken with or without food.

Monitoring to assess safety

- Obtain transaminase and bilirubin levels within 6 months before initiation of AUBAGIO therapy. Monitor ALT levels at least monthly for six months after starting AUBAGIO [see Warnings and Precautions (5.1)].
- Obtain a complete blood cell count (CBC) within 6 months before the initiation of treatment with AUBAGIO. Further monitoring should be based on signs and symptoms of infection [see Warnings and Precautions (5.4)].
- Prior to initiating AUBAGIO, screen patients for latent tuberculosis infection with a tuberculin skin test or blood test for mycobacterium tuberculosis infection [see Warnings and Precautions (5.7)].
- Check blood pressure before start of AUBAGIO treatment and periodically thereafter [see Warnings and Precautions (5.7)].

4.1. Severe Hepatic Impairment
Patients with severe hepatic impairment [see Warnings and Precautions (5.1)].

4.2. Patients Who are Pregnant or Women of Childbearing Potential Not Using Reliable Contraception
AUBAGIO may cause fetal harm when administered to a pregnant woman.

In animal studies, teriflunomide has been shown to be selectively teratogenic and embryolethal in multiple species when administered during pregnancy at doses less than those used clinically. Nonclinical studies indicate further that the intended pharmacologic action of the drug is involved in the mechanism of developmental toxicity [see Use in Specific Populations (8.1)].

AUBAGIO is contraindicated in women who are pregnant or women of child bearing potential not using reliable contraception. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to a fetus. If pregnancy does occur during treatment, the drug should be immediately discontinued and an accelerated elimination procedure should be initiated [see Warnings and Precautions (5.3)]. Under these conditions, the patient should be referred to an obstetrician/gynecologist, preferably experienced in reproductive toxicity, for further evaluation and counseling [see Warnings and Precautions (5.7)].

4.3. Current treatment with leflunomide
Co-administration of teriflunomide with leflunomide is contraindicated.

5 WARNINGS AND PRECAUTIONS
5.1. Hepatotoxicity
Severe liver injury including fatal liver failure and dysfunction has been reported in some patients treated with leflunomide, which is indicated for rheumatoid arthritis. A similar risk would be expected for teriflunomide because recommended doses of teriflunomide and leflunomide result in a similar range of plasma concentrations of teriflunomide. Patients with pre-existing liver disease may be at increased risk of developing elevated serum transaminases when taking AUBAGIO. Patients with pre-existing acute or chronic liver disease, or those with serum-alanineaminotransferase (ALT) greater than two times the upper limit of normal (ULN) before initiating treatment, should not normally be treated with AUBAGIO. AUBAGIO is contraindicated in patients with severe hepatic impairment [see Contraindications (4.1)].

In placebo-controlled trials, ALT greater than three times the ULN occurred in 61/1045 (5.8%) and 62/1002 (6.2%) of patients receiving AUBAGIO 7 mg and 14 mg, respectively, and 38/997 (3.8%) of patients receiving placebo during the treatment period. These elevations occurred mostly within the first year of treatment. Half of the cases returned to normal without drug discontinuation. In clinical trials, if ALT elevation was greater than three times the ULN on two consecutive tests, AUBAGIO was discontinued and patients underwent an accelerated elimination procedure [see Warnings and Precautions (5.3)]. Of the patients who underwent discontinuation and accelerated elimination in controlled trials, half returned to normal or near normal values within 2 months.

One patient in the controlled trials developed ALT 32 times the ULN and jaundice 5 months after initiation of AUBAGIO 14 mg treatment. The patient was hospitalized for 5 weeks and recovered after plasmapheresis and cholestyramine accelerated elimination procedure. AUBAGIO-induced liver injury in this patient could not be ruled out.

Obtain serum transaminase and bilirubin levels within 6 months before initiation of AUBAGIO therapy. Monitor ALT levels at least monthly for six months after starting AUBAGIO. Under additional monitoring when AUBAGIO is given with other potentially hepatotoxic drugs. Consider discontinuing AUBAGIO if serum transaminase increase (greater than three times the ULN) is confirmed. Monitor serum transaminase and bilirubin on AUBAGIO therapy, particularly in patients who develop symptoms suggestive of hepatic dysfunction, such as abdominal pain, nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine. If liver injury is suspected to be AUBAGIO-induced, discontinue AUBAGIO and start an accelerated elimination procedure [see Warnings and Precautions (5.3)] and monitor liver tests weekly until normalized. If AUBAGIO-induced liver injury is unlikely because some other probable cause has been found, resumption of AUBAGIO therapy may be considered.

5.2 Use in Women of Childbearing Potential
There are no adequate and well-controlled studies evaluating AUBAGIO in pregnant women. However, based on animal studies, teriflunomide may increase the risk of teratogenic effects or fetal death when administered to a pregnant woman [see Contraindications (4.2)].

Women of childbearing potential must not be started on AUBAGIO until pregnancy is excluded and it has been confirmed that they are using reliable contraception. Before starting treatment with AUBAGIO, patients must be fully counseled on the potential for serious risk to the fetus. The patient must be advised that if there is any delay in onset of menses or any other reason to suspect pregnancy, they must notify their physician immediately for pregnancy testing and, if pregnancy is confirmed, the physician and patient must discuss the risk to the fetus. It is possible that rapidly lowering the plasma concentration of teriflunomide by instituting an accelerated elimination procedure may decrease the risk to the fetus from AUBAGIO [see Warnings and Precautions (5.3)].

Upon discontinuing AUBAGIO, it is recommended that all women of childbearing potential undergo an accelerated elimination procedure. Women receiving AUBAGIO treatment who wish to become pregnant must discontinue AUBAGIO and undergo an accelerated elimination procedure, which reduces teriflunomide plasma concentrations to less than 0.02 mg/L (0.02 mcg/mL). Human plasma concentrations of teriflunomide less than 0.02 mg/L (0.02 mcg/mL) are expected to have minimal risk [see Contraindications (4.2), Warnings and Precautions (5.3) and Use in Specific Populations (8.1)].

5.3 Procedure for Accelerated Elimination of Teriflunomide
Teriflunomide is eliminated slowly from the plasma. Without an accelerated elimination procedure, it takes on average 8 months to reach plasma concentrations less than 0.02 mg/L (0.02 mcg/mL). In placebo-controlled trials with 7 mg and 14 mg of AUBAGIO compared with 7% of patients receiving AUBAGIO 7 mg and 14 mg, respectively, with 7% of patients receiving placebo; lymphocyte count <0.8×10⁹/L was observed in 10% and 12% of patients.

If either elimination procedure is poorly tolerated, treatment days do not need to be consecutive. In placebo-controlled trials, 1.5×10⁹/L was observed in 12% and 16% of patients receiving AUBAGIO 7 mg and 14 mg, respectively, and 0.8×10⁹/L was observed in 10% and 12% of patients receiving placebo; lymphocyte count <0.8×10⁹/L was observed in 10% and 12% of patients.
Malignancy

For patients testing positive in tuberculosis screening, treat by standard medical practice. Resolution of tuberculosis infection(s) is resolved with continued treatment. Peripheral neuropathy also occurred in placebo-treated patients, but larger and longer-term studies would be needed to determine whether there is an increased risk of malignancy or lymphoproliferative disorders with AUBAGIO. However, in placebo-controlled studies, peripheral neuropathy, including both polyneuropathy and mononeuropathy (e.g., carpal tunnel syndrome), occurred more frequently in patients taking AUBAGIO than in patients taking placebo. The incidence of peripheral neuropathy and the safety of AUBAGIO in individuals with latent tuberculosis infection is unknown. For patients testing positive in tuberculosis screening, treat by standard medical practice prior to therapy with AUBAGIO.

Vaccination

No clinical data are available on the efficacy and safety of live vaccinations in patients taking AUBAGIO. Vaccination with live vaccines is not recommended. The long half-life of AUBAGIO should be considered when contemplating administration of a live vaccine after stopping AUBAGIO.

5.5 Peripheral Neuropathy

In placebo-controlled studies, peripheral neuropathy, including both polyneuropathy and mononeuropathy (e.g., carpal tunnel syndrome), occurred more frequently in patients taking AUBAGIO than in patients taking placebo. The incidence of peripheral neuropathy confirmed by nerve conduction studies was 11.4% (116 patients) and 1.9% (17 patients) of patients receiving 7 mg and 14 mg of AUBAGIO, respectively, compared with 0.4% receiving placebo (4 patients). Treatment was discontinued in 0.7% (8 patients) with confirmed peripheral neuropathy (3 patients receiving AUBAGIO 7 mg and 5 patients receiving AUBAGIO 14 mg). Headache and nausea were the most common adverse events associated with discontinuation. Not all cases of peripheral neuropathy resolved with continued treatment. Peripheral neuropathy also occurred in patients receiving leflunomide.

Age older than 60 years, concomitant neuropathy medications, and diabetes may increase the risk for peripheral neuropathy. If a patient taking AUBAGIO develops symptoms consistent with peripheral neuropathy, such as bilateral numbness or tingling of hands or feet, consider discontinuing AUBAGIO therapy and initiating an accelerated elimination procedure.[see Warnings and Precautions (5.3)].

Table 1. Adverse Reactions in Placebo-Controlled Studies in Patients with Relapsing Forms of Multiple Sclerosis

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>AUBAGIO 7 mg (N=1045)</th>
<th>AUBAGIO 14 mg (N=1002)</th>
<th>Placebo (N=997)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>18%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Nausea</td>
<td>2%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>8%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

5.6 Skin Reactions

Rare cases of Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported in patients with rheumatoid arthritis receiving leflunomide. A similar risk would be expected for AUBAGIO.[see Clinical Pharmacology (12.3) in the full prescribing information]. If a patient taking AUBAGIO develops any of these conditions, stop AUBAGIO therapy and perform an accelerated elimination procedure.[see Warnings and Precautions (5.3)].

5.7 Increased Blood Pressure

In placebo-controlled studies, the mean change from baseline to the end of study in systolic blood pressure was +2.3 mmHg and +2.7 mmHg for AUBAGIO 7 mg and 14 mg, respectively. Mean changes from baseline in diastolic blood pressure was +1.4 mmHg and +1.9 mmHg for AUBAGIO 7 mg and 14 mg, respectively, and -0.3 mmHg for placebo. Hypertension was an adverse reaction in 3.1% and 4.3% of patients treated with 7 mg or 14 mg of AUBAGIO compared with 1.8% for placebo. Check blood pressure before start of AUBAGIO treatment and periodically thereafter. Elevated blood pressure should be appropriately managed during treatment with AUBAGIO.

5.8 Respiratory Effects

Intermittent disease activity and worsening of pre-existing interstitial lung disease have been reported during treatment with leflunomide. A similar risk would be expected for AUBAGIO.[see Clinical Pharmacology (12.3) in the full prescribing information].

5.9 Concomitant Use with Immunosuppressive or Immunomodulating Therapies

Co-administration with an antineoplastic, or immunosuppressive therapies used for treatment of multiple sclerosis has not been evaluated. Safety studies in which AUBAGIO was concomitantly administered with other immunomodulating therapies for up to one year (interferon beta, glatiramer acetate) did not reveal any specific safety concerns. The long term safety of these combinations in the treatment of multiple sclerosis has not been established.

6 ADVERSE REACTIONS

The following serious adverse reactions are described elsewhere in the prescribing information:

- Hepatotoxicity [see Contraindications (4.1) and Warnings and Precautions (5.1)]
- Bone Marrow Effects/Immunosuppression Potential/Infections [see Warnings and Precautions (5.4)]
- Peripheral Neuropathy [see Warnings and Precautions (5.5)]
- Skin Reactions [see Warnings and Precautions (5.6)]
- Increased Blood Pressure [see Warnings and Precautions (5.7)]
- Respiratory Effects [see Warnings and Precautions (5.8)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

A total of 2047 patients receiving AUBAGIO (7 mg or 14 mg once daily) constituted the safety population in the pooled analysis of placebo-controlled studies in patients with relapsing forms of multiple sclerosis; of these, 71% were female. The average age was 37 years.

Table 1 lists adverse reactions in placebo-controlled trials with rates that were at least 2% for AUBAGIO patients and also at least 2% above the rate in placebo patients. The most common were headache, an increased ALT, diarrhea, alopecia, and nausea. The adverse reaction most commonly associated with discontinuation was an increase in ALT (3.2%, 2.6%, and 2.3% of all patients in the AUBAGIO 7 mg, AUBAGIO 14 mg, and placebo treatment arms, respectively).
patients; 4% of AUBAGIO-treated patients had hypophosphatemia with serum phosphorus levels at least 0.3 mmol/L but less than 0.6 mmol/L, compared to 0.8% of placebo-treated patients. No patient in any treatment group had a serum phosphorus below 0.3 mmol/L.

7 DRUG INTERACTIONS
Effect of AUBAGIO on CYP2C8 substrates
Teriflunomide is an inhibitor of CYP2C8 in vivo. In patients taking AUBAGIO, exposure of drugs metabolized by CYP2C8 (e.g., piacitaxel, pioglitazone, repaglinide, rosiglitazone) may be increased. Monitor these patients and adjust the dose of the concomitant drug(s) metabolized by CYP2C8 as required [see Clinical Pharmacology (12.3) in the full prescribing information].

Effect of AUBAGIO on warfarin
Co-administration of AUBAGIO with warfarin requires close monitoring of the international normalized ratio (INR) because AUBAGIO may decrease peak INR by approximately 25%.

Effect of AUBAGIO on oral contraceptives
AUBAGIO may increase the systemic exposures of ethinylestradiol and levonorgestrel. Consideration should be given to the type or dose of contraceptives used in combination with AUBAGIO [see Clinical Pharmacology (12.3) in the full prescribing information].

Effect of AUBAGIO on CYP1A2 substrates
Teriflunomide may be a weak inducer of CYP1A2 in vivo. In patients taking AUBAGIO, exposure of drugs metabolized by CYP1A2 (e.g., alorsetron, duloxetine, theophylline, tizanidine) may be reduced. Monitor these patients and adjust the dose of the concomitant drug(s) metabolized by CYP1A2 as required [see Clinical Pharmacology (12.3) in the full prescribing information].

Effect of AUBAGIO on organic anion transporting polypeptide (OATP) substrates
Teriflunomide inhibits the activity of OAT3 in vivo. In patients taking AUBAGIO, exposure of drugs which are OAT3 substrates (e.g., cefaclor, cimetidine, ciprofloxacin, penicillin G, ketoprofen, furosemide, methotrexate, zidovudine) may be increased. Monitor these patients and adjust the dose of the concomitant drug(s) which are OAT3 substrates as required [see Clinical Pharmacology (12.3) in the full prescribing information].

Effect of AUBAGIO on BCRP and organic anion transporting polypeptide (OATP) substrates
Teriflunomide inhibits the activity of BCRP and OATP1B1/1B3 in vivo. For a patient taking AUBAGIO, the dose of rosuvastatin should not exceed 10 mg once daily. For other substrates of BCRP (e.g., mitoxantrone) and drugs in the OATP family (e.g., methotrexate, rifampin), especially HMG-Co reductase inhibitors (e.g., atorvastatin, niacin, lovastatin, pravastatin, simvastatin), consider reducing the dose of these drugs and monitor patients closely for signs and symptoms of increased exposures to the drugs while patients are taking AUBAGIO [see Clinical Pharmacology (12.3) in the full prescribing information].

8 USE IN SPECIFIC POPULATIONS
8.1 Pregnancy
Pregnancy Category X [see Contraindications (4.2) and Warnings and Precautions (5.2)]
When teriflunomide (oral doses of 1, 3, or 10 mg/kg/day) was administered to pregnant rats throughout the period of organogenesis, high incidences of fetal malformation (primarily craniofacial, and axial and appendicular skeletal defects) and embryofetal death were observed at doses not associated with maternal toxicity. Adverse effects on embryofetal development were observed following dosing at various stages throughout organogenesis. Maternal plasma exposure at the no-effect level (1.0 mg/kg/day) for embryofetal developmental toxicity in rats was less than that in humans at the maximum recommended human dose (MRHD, 14 mg /day).

Administration of teriflunomide (oral doses of 1, 3.5, or 12 mg/kg/day) to pregnant rabbits throughout organogenesis resulted in high incidences of fetal malformation (primarily craniofacial, and axial and appendicular skeletal defects) and embryofetal death at doses associated with minimal maternal toxicity. Maternal plasma exposure at the no-effect dose (1.0 mg/kg/day) for embryofetal developmental toxicity in rabbits was less than that in humans at the MRHD.

In studies in which teriflunomide (oral doses of 0.05, 0.1, 0.3, 0.6, or 1.0 mg/kg/day) was administered to rats during gestation and lactation, decreased growth, eye and skin anomalies, and high incidences of malformation (limb defects) and postnatal death were observed in the offspring at doses not associated with maternal toxicity. Maternal plasma exposure at the no-effect dose for pre- and postnatal developmental toxicity in rats (0.10 mg/kg/day) was less than that in humans at the MRHD.

In animal reproduction studies of leflunomide, embryolethality and teratogenic effects were observed in pregnant rat and rabbit at or below clinically relevant plasma teriflunomide exposures (AUC). In published reproduction studies in pregnant mice, leflunomide was embryolethal and increased the incidence of malformations (craniofacial, axial, skeletal, heart and great vessel). Supplementation with exogenous uridine reduced the teratogenic effects in pregnant mice, suggesting that the mode of action (inhibition of mitochondrial enzyme dihydroorotate dehydrogenase) is the same for therapeutic efficacy and developmental toxicity. At recommended doses in humans, teriflunomide and leflunomide result in a similar range of plasma concentrations of teriflunomide.

Use in Males
AUBAGIO is detected in human semen. Animal studies to specifically evaluate the risk of teratogenicity have not been conducted. To minimize any possible risk, men not wishing to father a child and their female partners should use reliable contraception. Men wishing to father a child should discontinue use of AUBAGIO and undergo an accelerated elimination procedure to decrease the plasma concentration of teriflunomide to less than 0.02 mg/L (0.02 mcg/mL) [see Warnings and Precautions (5.3)].

8.2 Nursing Mothers
Teriflunomide was detected in rat milk following a single oral dose of teriflunomide. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from AUBAGIO a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.3 Pediatric Use
Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use
Clinical studies of AUBAGIO did not include patients over 65 years old.

8.6 Hepatic Impairment
No dosage adjustment is necessary for patients with mild and moderate hepatic impairment. The pharmacokinetics of teriflunomide in severe hepatic impairment have not been evaluated. AUBAGIO is contraindicated in patients with severe hepatic impairment [see Contraindications (4.1) Warnings and Precautions (5.1), and Clinical Pharmacology (12.3) in the full prescribing information].

8.7 Renal Impairment
No dosage adjustment is necessary for patients with mild, moderate, and severe renal impairment [see Clinical Pharmacology (12.3) in the full prescribing information].

10 OVERDOSAGE
There is no experience regarding teriflunomide overdose or intoxication in humans. Teriflunomide 70 mg daily up to 14 days was well tolerated by healthy subjects. In the event of clinically significant overdose or toxicity, cholestyramine or activated charcoal is recommended to accelerate elimination [see Warnings and Precautions (5.3)].

Sanofi/Genzyme - 143160
Creative: TER-BPLR-SA-OCT14

AUBAGIO®
(teriflunomide) tablets, for oral use
AUBAGIO and undergo an accelerated elimination procedure to decrease the plasma concentration of teriflunomide to less than 0.02 mg/L (0.02 mcg/mL) [see Warnings and Precautions (5.3)].

Pregnancy Registry
Although AUBAGIO is contraindicated in pregnancy, a pregnancy registry has been established to monitor fetal outcomes of pregnant women exposed to AUBAGIO. Physicians are encouraged to enroll pregnant women in the AUBAGIO pregnancy registry, or pregnant women may enroll themselves, by calling 1-800-745-4447, option 4.
AAN member residents are encouraged to apply to serve on the Continuum® Editorial Board. The Continuum Editorial Board provides oversight of Continuum: Lifelong Learning in Neurology®, the official CME journal of the AAN, and the companion product, Continuum® Audio. The Editorial Board is responsible for topic and guest editor selection and review and evaluation of issues in accordance with the ACCME.

One resident will be selected to serve a one-year term on the board beginning in May 2016, representing the perspective of Junior members of the Academy for Continuum, which is provided at no cost to all Junior members.

Katie Grouse, MD, who is completing her term as the resident board member in April, said, “My experience as a resident member of the Continuum editorial board was invaluable. As I was invited to attend the editorial board meetings, I was involved in all steps of the reviewing process. This was an excellent opportunity to learn how a high-quality academic publication is created.”

The member is expected to attend two Editorial Board meetings per year, one in the fall and one at the AAN Annual Meeting in 2017. Residents should be in PGY3 or PGY4 at the time of application.

“Having a neurology resident on our editorial board provides an important voice to our trainees in the direction of Continuum, while at the same time providing a unique opportunity for a resident to learn the ‘ins and outs’ of production of a major clinical journal,” said Continuum Editor-in-Chief Steven L. Lewis, MD, FAAN.

To apply, candidates should submit a one-page letter of interest, CV, and a letter of recommendation from their program director or department chair to Executive Editor, Education and News Publications, Andrea Weiss at aweiss@aan.com by March 1, 2016.

For more information, contact Andrea Weiss at aweiss@aan.com.

Medical Students:
Apply for $3,000 Summer Research Scholarship by February 5

Applications are being sought for up to 20 Medical Student Summer Research Scholarships for 2016. The scholarships offer AAN medical student members in a registered SIGN chapter and with little or no prior research history a summer stipend of $3,000 to conduct a neuroscience-based project with clearly defined goals. Projects must be completed through a US or Canadian institutional, clinical, or laboratory setting of the student’s choice where there are ongoing programs of research, service, or training, or through a private practice. Preference will be given to beginning researchers, and projects already completed will not be considered.

For additional application and project criteria, visit http://bit.ly/MOUYOr. For more information, contact Cheryl Alementi at calementi@aan.com or (612) 928-6073.
Trainees

March 4 Is Deadline for 2016 Medical Student Prize for Excellence Nominations

In an effort to promote neurology as a specialty and as a potential career among undergraduate medical students, the AAN is seeking nominations from medical school faculty for its 2016 Medical Student Prize for Excellence.

Ideal candidates should have outstanding evaluations and recommendations from faculty and residents and show the most promise for a career in neurology. If available, excellent performance on the neurology shelf exam or equivalent examination may offer as supporting criteria. If more than one student fulfills these criteria, the student who shows the most promise for a career in neurology should be nominated.

Award recipients will receive a check and a certificate on behalf of the AAN during their institution’s graduation/awards ceremony. Neurology clerkship directors, department chairs (and/or their designees), and neurology residents should evaluate the performance of all graduating medical students in the clinical neurology clerkship and choose one student from each medical school as recipient. The award will be in addition to, and separate from, any other neurology award given to graduates at the local or institutional level.

For more information and to nominate one of your graduating medical students, visit http://bit.ly/1lqwzVVv before the March 4, 2016, deadline. Incomplete applications and applications received after March 4 will not be considered. For more information, contact Cheryl Alementi at calementi@aan.com or (612) 928-6073.

Call for Entries

Online video contest

Share Your Story for a Chance to Win $1,000

Submit a video about how brain disease—such as Alzheimer’s disease, stroke, concussion, epilepsy, ALS, Parkinson’s disease, MS, and others—has affected you or a loved one’s life.

The Neuro Film Festival aims to raise awareness about why more funding is needed for brain disease research.

DEADLINE: March 1, 2016
NeuroFilmFestival.com

Presented by:
Membership

Academy Offers Discounted Membership Rates as Low as $100 for Nurse Practitioners, Physician Assistants

The AAN recognizes that nurse practitioners and physician assistants play a critical role in the neurology care team. That’s why we are offering two heavily discounted options for these important care team members to join the Academy and gain access to a host of exclusive opportunities to help them excel in their careers and provide the best possible patient care.

$250 membership option includes:
- FREE AAN online education resources: NeuroSAE®, NeuroPISM, and NeuroLearnSM
- Publications like Neurology® and Neurology® Clinical Practice featuring the latest research and breaking news you need to know
- Access to AAN Clinical Practice Guidelines—now on your smart phone!
- Deep discounts on Continuum: Lifelong Learning in Neurology®
- Discounted registration to the 2016 AAN Annual Meeting in Vancouver, BC, Canada
- Year-round networking opportunities with neurology’s leaders
- Access to member-only tools on AAN.com, the leading online resource for神经ologists worldwide
- Much more!

$100 membership option includes:
- All of the benefits listed under the $250 membership, excluding Neurology (print and digital access), Neurology Today (print) and free access to NeuroSAE, NeuroPISM, and NeuroLearn.

Improve your practice’s efficiency and encourage your care team members to join the AAN. If you are already a valued Nurse Practitioner or Physician Assistant member and have not yet renewed for 2016, visit AAN.com/dues.

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Subscribe or renew today at lww.com/continuum—Select the AAN member price type to receive a 63% discount.
African Neurologists Benefit from AAN-sponsored Educational Opportunity

Last fall, AAN member Farrah J. Mateen, MD, PhD, travelled to Khartoum, Sudan, on behalf of the Academy to teach neurology at the 7th Annual Sub-Saharan African Regional Teaching Course.

Each year’s intensive three-day program is held in a different African city to provide new education opportunities to young African neurologists, neurologists-in-training, postgraduates, and new faculty members in academic neurology. Organized locally by AAN member Osheik A. Seidi, MD, MRCP, ABIM, professor of neurology at the University of Khartoum, the recent event drew participants working in more than 20 African countries, from Madagascar to Djibouti to Cameroon.

Student scholarships were provided through the generosity of the European Academy of Neurology and other professional neurologic societies, including the AAN, which began participating in 2014. Mateen was joined by representatives from the World Stroke Organization, European Headache Federation, International League Against Epilepsy, International Parkinson and Movement Disorders Society, and Pan-African Association of Neurological Societies, among others.

“Many thought leaders in African neurology were present,” said Mateen, “providing a diverse and rich social network of formal and informal educational opportunities for all involved.” Mateen is assistant professor in the Department of Neurology at the Massachusetts General Hospital at Harvard Medical School, and chairs the AAN’s Global Health Section. Her awards from the AAN include the Lawrence C. McHenry Award for the History of Neurology (2014), the Founders’ Alliance Award (2010), the Roland P. MacKay Award (2005), and an American Brain Foundation Practice Research Training Fellowship (2010–2012). She is an experienced international traveler, having journeyed to many countries including Bangladesh, Bhutan, India, China, Laos, Timor-Leste, Jordan, Lebanon, Peru, Cameroon, Zimbabwe, Botswana, Uganda, and elsewhere in her work as a neurologist.

“The Sudanese organizers asked me to make official remarks at the opening ceremonies at the Ministry of Higher Education in Khartoum, during which I was able to bring greetings on behalf of the AAN to the African delegations and our kind Sudanese hosts. I was pleased to publicly congratulate African neurologists and neurologists-in-training for rising to the formidable challenge of meeting the needs of a very high number of neurological patients in their home countries. Their work should make us all very proud.”

The centerpieces of discussion were stroke and pediatric neurology. Mateen’s lecture focused on infectious causes of stroke, a topic requested by the organizers and one germane to her PhD studies in international health. “I also engaged in case-based teaching discussions on various aspects of diagnosis and management of multiple sclerosis and related autoimmune diseases of the central nervous system.”

While serving as an instructor, Mateen also was an avid pupil. “I was able to formally survey the African attendees on their educational backgrounds, training experiences, access to technology, and unmet needs for practical neurological skills. I hope the forthcoming report of this survey will provide a snapshot of the existing landscape for future efforts for African neurology training at the postgraduate level.”

Education events typically enlighten the students more than the teachers, but for Mateen it was clearly a two-way street. “I learned many things through my experiences with the Sudanese hosts and my discussions with the students and faculty. These include the power of the social network of neurologists and how it has shaped my experience of neurology, how very fortunate we are to have strong professional advocacy for our work in the US, and how meaningful it is to work synergistically at an international scale. This involves promoting our field of neurology to students contemplating their next career steps, governments setting new priorities, and faculty developing research and clinical training infrastructure for the new generation of African neurologists. I was proud to represent our Academy at such an important event and inspired by the AAN’s strong support of our shared goal to promote African neurology, rising to the challenges ahead. Next year’s meeting is in Burkina Faso, and I encourage the Academy and its members to support this well-organized and truly meaningful endeavor.”

Farrah J. Mateen, MD, PhD
Standing Strong Event Raises More than $100,000 for Brain Research

More than 160 attendees gathered on Wednesday, November 18, 2015, and raised nearly $51,000—which was doubled thanks to a generous anonymous match—for “Standing Strong: An Evening Benefiting Brain Disease Research.” The special event was held at the TCF Bank Stadium, home to the University of Minnesota Gophers and the Minnesota Vikings, in Minneapolis, MN. The evening featured a reception in the world-class stadium locker room; a rare behind-the-scenes tour of generally restricted areas; a private musical performance by Super Bowl Champion, concussion patient, and National Spokesperson for the American Brain Foundation and AAN, Ben Utecht; and a moving speech from former US Vice President and Honorary Chairman of the American Brain Foundation, Walter F. Mondale. •
Make a year-end gift that will go twice as far.

All donations for the year-end campaign will be matched dollar-for-dollar by the American Academy of Neurology. Donate today at abf.convio.net/yearend.
Neurology Position with Central Maine Medical Center

Central Maine Medical Group is seeking a BE/BC neurologist to join an established adult neurology practice primarily associated with Central Maine Medical Center. A focused interest in stroke, muscle disease, headache/migraine, epilepsy, or movement disorder would be a welcome addition, but is not required. Our diagnostic capabilities include 1.5T MRI, CT angiography, Evoked Potentials, EEG, and 24-72 Hour Ambulatory EEG. We also have an active Teleneurology service that is affiliated with Massachusetts General Hospital. Central Maine Medical Center is the flagship hospital of Central Maine Healthcare. The medical center has 250 inpatient beds and offers a broad range of services that include, among many, neurosurgery, a Level II trauma center, cardiovascular medicine, vascular and cardiac surgery, and medical and radiation oncology. The Central Maine Medical Group comprises of approximately 350 providers, approximately half of which are in primary care. The group delivers care across almost 2500 square miles at numerous outpatient sites and four hospitals. A competitive salary and attractive benefits package are enhanced by the scenic beauty and abundant outdoor adventure found in Maine. Interested candidates, please send CV to Gina Mallozzi, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240, Fax: 207/796-5696, email: MallozGi@cmhc.org, or call: 800/445-7431. Not a J1 Opportunity.

Fellowship in Neuroimaging

Winchester Neurological Consultants, Inc., in conjunction with Virginia Commonwealth University and Winchester Medical Center, is offering a clinical Neuroimaging Fellowship for BC/BE neurology graduates that can be completed in one or two years. Located approximately an hour from Washington, DC, our United Council of Neurologic Subspecialties fully accredited fellowship offers extensive training in the performance and interpretation of diagnostic inpatient and outpatient MRI, CT, Doppler, TCD, and myelography, utilizing four state of the art MRI scanners and four multi-slice CT units. Responsibilities include supervision and interpretation of imaging, assisting with acute stroke protocols, and direct patient care. Availability: immediate. Research interests are encouraged. Salary is $60,000.00 plus benefits. There is also an option to combine the imaging fellowship with a NeuroHospitalist Fellowship over a two year training period with a salary of $80,000.00 per year. CV’s should be emailed to gsteele@winchesterneurological.com

Neurology Private Practice Opportunity in Northeast Metro Atlanta

The Longstreet Clinic, PC, in Gainesville, Georgia, is recruiting a Neurology Resident/Fellow to join our Department of Neurology. This state-of-the-art Neurology practice offers in-house EMGs and EEGs, as well as Chemodenervation, evaluation and programming for Deep Brain Stimulation and Vagal Nerve Stimulation. We’ve opened a Balance Lab adjacent to our Neurology office. The Longstreet Clinic, PC (TLC), is a multi-specialty, physician-owned medical group. In 2015, TLC was ranked by Atlanta Business Chronicle as the seventh largest physician group practice in Georgia, and second largest independent group practice in Georgia. TLC is a 160+ provider group offering physicians the opportunity to build their practices within an innovative, financially sound and collaborative organization. Competitive compensation and benefits including pension plan, 401(k) and CME. Relocation allowance, signing bonus and shareholder opportunity to include real estate holdings. Please contact Julie King at (770) 533-6593 or j.king@longstreetclinic.com for additional information about our practice opportunities. www.longstreetclinic.com

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Neurology Openings with Dignity Health in Northern California

Join a Dignity Health Medical Group in Northern California! Do you desire: Livework in California? Benefits of Traditional employment model? Develop full scope outpatient practice (inpatient practice available if desired?) Affordable real estate? Practice highlights include: Tele Neurology services in place with Affiliate Group; Joint Commission-Certified Primary Stroke Centers. No ED call practice options (Red Bluff and Stockton). Medical Foundation aligned with the one of the largest health systems in the nation and the largest hospital system in California. Compensation includes: Competitive salary guarantee & bonus incentive. Attractive benefits package including paid malpractice. Generous time off. Community highlights include: Proximity to San Francisco, Monterey and Sacramento. Excellent top-ranked public schools. Multi-cultural arts, cuisine, theater and outdoor activities. Group locations: Red Bluff, Redding, Stockton. For more information, please contact & send your CV to: Physician Recruiting, providers@dignityhealth.org; Phone: (888) 599.7787; www.dignityhealth.org/physician-careers.

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Vancouver, BC, Canada

JANUARY 2016

JANUARY 1
Application Available: UCNS Headache Medicine Certification and Recertification Examinations
UCNS.org/go/subspecialty/headache/certification

JANUARY 7
Application Deadline: AAN Diversity Leadership
AAN.com/view/DiversityLeadershipProgram

JANUARY 10
Application Deadline: Palatucci Advisory Leadership Forum
AAN.com/view/2016PALF

JANUARY 12
Webinar: Break the Code, Or It Will Break Your Practice—Coding for Neurodiagnostic Procedures
(Register by January 11)
AAN.com/view/pmw16

JANUARY 15–18
Breakthroughs in Neurology Conference
AAN.com/view/Breakthroughs

JANUARY 31
Application Deadline: 2017 A.B. Baker Lifetime Achievement Award
http://bit.ly/1NdpiTk

JANUARY 31
Application Deadline: 2016 A.B. Baker Teacher Recognition Award
http://bit.ly/1Lbgnkw

FEBRUARY 2016

FEBRUARY 1
Application Available: UCNS Behavioral Neurology & Neuropsychiatry Certification and Recertification Examinations
UCNS.org/go/subspecialty/behavioral/certification

FEBRUARY 5
Application Deadline: 2016 Medical Student Summer Research Scholarships

FEBRUARY 9
/Register by February 8
AAN.com/view/pmw16

FEBRUARY 24
Hotel Reservation Deadline:
AAN Annual Meeting
AAN.com/view/AM16

MARCH 2016

MARCH 1
Video Submission Deadline:
2016 Neuro Film Festival
NeuroFilmFestival.com

MARCH 4
Application Deadline: 2016 Medical Student Prize for Excellence
http://bit.ly/1lqwzWw

MARCH 8
Webinar: Get Caught Up: The ICD-10-CM Cross-walk Is Now a Cross-run
(Register by March 7)
AAN.com/view/pmw16

MARCH 22
Webinar: Documentation into Dollars: Evaluation/Management
/Register by March 21
AAN.com/view/pmw16

MARCH 24
Early Registration Deadline:
AAN Annual Meeting
AAN.com/view/AM16

MARCH 31

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Application Deadline: AAN Diversity Leadership
AAN.com/view/DiversityLeadershipProgram

JANUARY 10
Application Deadline: Palatucci Advisory Leadership Forum
AAN.com/view/2016PALF

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http://bit.ly/1NdpiTk

JANUARY 31
Application Deadline: 2016 A.B. Baker Teacher Recognition Award
http://bit.ly/1Lbgnkw
BRIEF SUMMARY OF PRESCRIBING INFORMATION FOR ZECUITY® (sumatriptan intranasal transdermal system)

SEE PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

ZECUITY is indicated for the acute treatment of migraine with or without aura in adults.

Limitations of Use:

- Use only if a clear diagnosis of migraine has been established.
- If a patient has no response to the first migraine attack treated with ZECUITY, reconsider the diagnosis of migraine prior to treating any subsequent attacks.
- ZECUITY is not intended for the prevention of migraine attacks.

CONTRAINDICATIONS

ZECUITY is contraindicated in patients with:

- Ischemic coronary artery disease (CAD) (angina pectoris, history of myocardial infarction, or documented silent ischemia) or coronary artery vasospasm, including Prinzmetal's angina.
- Wolff-Parkinson-White syndrome or arrhythmias associated with other cardiac accessory conduction pathway disorders.
- History of stroke, transient ischemic attack (TIA), or history of hemiplegic or basilar migraine because these patients are at a higher risk of stroke.
- Peripheral vascular disease.
- Ischemic bowel disease.
- Uncontrolled hypertension.
- Recent (i.e., within 24 hours) use of ergotamine-containing medication, ergot-type medication (such as dihydroergotamine or methysergide), or another 5-hydroxytryptamine (5-HT) agonist (see Drug Interactions).
- Concurrent administration of a MAO-A inhibitor or recent (within 2 weeks) use of a MAO-A inhibitor.
- Known hypersensitivity to sumatriptan or components of ZECUITY.
- Severe hepatic impairment.
- Allergic contact dermatitis to ZECUITY.

WARNINGS AND PRECAUTIONS

Risk of Injury During Magnetic Resonance Imaging (MRI) Procedure

ZECUITY contains metal parts and must be removed before an MRI procedure.

Allergic Contact Dermatitis

Use of ZECUITY may lead to allergic contact dermatitis (ACD). In two long-term open-label studies where patients were allowed to treat multiple migraine attacks for up to 1 year, the overall adverse event rate of ACD was 4%. ZECUITY should be discontinued if ACD is suspected. Erythema is commonly seen with use of ZECUITY and is not by itself an indication of sensitization. Following sensitization with ZECUITY, erythematous plaque and/or erythema-vascular or erythema-to-bullous eruptions may develop. Clinical course is characterized by crescendo phenomenon of worsening pruritus and appearance over time with slower resolution to normal of affected skin areas.

Patients who have developed a reaction to ZECUITY, as evidenced by development of ACD, may develop systemic sensitization or other systemic reactions if sumatriptan-containing products are taken via other routes, e.g., orally or subcutaneously. It is possible that some patients who developed ACD with sumatriptan by exposure to ZECUITY and who have developed systemic sensitization, may not be able to take sumatriptan in any form.

Patients who develop ACD with ZECUITY and require treatment with sumatriptan via other routes should receive their first subsequent dose under close medical supervision.

Myocardial Ischemia, Myocardial Infarction, and Prinzmetal's Angina

The use of ZECUITY is contraindicated in patients with ischemic or vasospastic CAD. There have been rare reports of serious cardiac adverse reactions, including acute myocardial infarction, occurring within a few hours following administration of sumatriptan. Some of these reactions occurred in patients without known CAD. 5-HT3 agonists, including ZECUITY, may cause coronary artery vasospasm (Prinzmetal's angina), even in patients without a history of CAD.

Perform a cardiovascular evaluation in tripant-naive patients who have multiple cardiovascular risk factors (e.g., increased age, diabetes, hypertension, smoking, obesity, use of >25 mg of CAD) prior to using ZECUITY. Do not use ZECUITY if there is evidence of CAD or coronary artery vasospasm. (see Contraindications).

For patients with multiple cardiovascular risk factors who have a negative cardiovascular evaluation, consider using the first ZECUITY TDS in a medically supervised setting and performing an electrocardiogram (ECG) upon activation of ZECUITY. For such patients, consider periodic cardiovascular evaluation in intermittent long-term users of ZECUITY.

Arrhythmias

Life-threatening disturbances of cardiac rhythm, including ventricular tachycardia and ventricular fibrillation leading to death, have been reported within a few hours following the administration of 5-HT3 antagonists. Discontinue ZECUITY if these disturbances occur. ZECUITY is contraindicated in patients with Wolff-Parkinson-White syndrome or arrhythmias associated with other cardiac accessory conduction pathway disorders. (see Contraindications).

Chest, Throat, Neck or Jaw Pain/ Tightness/ Pressure

Sensations of tightness, pain, pressure, and heaviness in the chest, throat, neck, and jaw commonly occur after treatment with sumatriptan and are usually non-cardiac in origin. However, perform a cardiac evaluation if these patients are at high cardiac risk. The use of ZECUITY is contraindicated in patients shown with CAD and those with Prinzmetal's variant angina. (see Contraindications).

Cerebrovascular Events

Cerebral hemorrhage, subarachnoid hemorrhage, and stroke have occurred in patients treated with 5-HT3 antagonists, and some have resulted in fatalities. In a November 2011 report, 6 cases of stroke or TIA associated with ZECUITY were reported, 1 of which was fatal. The 5-HT3 antagonists having been administered in the incorrect belief that the symptoms experienced were a consequence of migraine when they were not. As with other acute migraine therapies, before treating headaches in patients not previously diagnosed as migraineurs, and in migraineurs who present with atypical symptoms, exclude other potentially serious neurological conditions. ZECUITY is contraindicated in patients with a history of stroke or TIA. (see Contraindications).

Other Vasospasm Reactions

5-HT3 agonists, including ZECUITY, may cause non-coronary vasospastic reactions, such as peripheral vascular ischemia, gastrointestinal vascular ischemia and infarction (presenting with abdominal pain and bloody diarrhea), splenic infarction, and Raynaud's syndrome. In patients who experience symptoms or signs suggestive of a vasospastic reaction following the use of any 5-HT3 agonist, rule out a vasospastic reaction before using ZECUITY. Reports of transient and permanent blindness and significant peripheral vision loss have been reported with the use of 5-HT3 agonists. Since visual disorders may be part of a migraine attack, a causal relationship between these events and the use of 5-HT3 agonists have not been clearly established.

Medication Overuse Headache

Overuse of acute migraine drugs (e.g., ergotamine, triptans, opioids, combination of drugs for 10 or more days per month) may lead to exacerbation of headache (medication overuse headache). Medication overuse headache may present as migraine-like daily headaches or as a marked increase in frequency of migraine attacks. Detoxification of patients with overuse of acute drugs and treatment of withdrawal symptoms (which often includes a transient worsening of headache) may be necessary.

Serpentin Syndrome

Serotonin syndrome may occur with triptans, including ZECUITY, particularly during coadministration with selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and MAO inhibitors (see Drug Interactions). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination), and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). The onset of symptoms usually occurs within minutes to hours of receiving a new or a greater dose of a serotonergic medication. Discontinue ZECUITY if serotonin syndrome is suspected.

Increase in Blood Pressure

Significant elevation in blood pressure, including hypertensive crisis with acute impairment of organ systems, has been reported on rare occasions in patients treated with 5-HT3 agonists, including ZECUITY. Increase in blood pressure has occurred in patients receiving ZECUITY. ZECUITY is contraindicated in patients with uncontrolled hypertension. (see Contraindications).

Anaphylactic/Anaphylactoid Reactions

Anaphylactic/anaphylactoid reactions have occurred in patients receiving sumatriptan. These reactions can be life threatening or fatal. In general, anaphylactic reactions to drugs are more likely to occur in individuals with a history of sensitivity to multiple allergens. ZECUITY is contraindicated in patients with prior serious anaphylactic reaction.

Seizures

Seizures have been reported following administration of sumatriptan. Some have occurred in patients with either a history of seizures or concurrent conditions predisposing to seizures. There are also reports in patients where no such predisposing factors are apparent. ZECUITY should be used with caution in patients with a history of epilepsy or conditions associated with a lowered seizure threshold.

Central Nervous System Reactivations

Electrolyte abnormalities, hypotension, and Raynaud's syndrome. In patients who experience symptoms or signs suggestive of a vasospastic reaction following the use of any 5-HT3 agonist, rule out a vasospastic reaction before using ZECUITY. Reports of transient and permanent blindness and significant peripheral vision loss have been reported with the use of 5-HT3 agonists. Since visual disorders may be part of a migraine attack, a causal relationship between these events and the use of 5-HT3 agonists have not been clearly established.

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In two long-term, open-label studies in which patients were allowed to treat multiple migraine attacks for up to 1 year, 15% (99 out of 662) withdrew from the study because of adverse reaction. The most common adverse reactions leading to withdrawal from the study were contact dermatitis (4%) and application site pain (4%). The most common adverse reactions (≥5%) in a controlled single dose study were application site pain, paresthesia, pruritus, warmth, and discomfort.

Controlled single dose acute migraine study

Table 1 lists adverse reactions that occurred at a frequency of 2% or greater in a controlled clinical study of ZECUITY in patients with acute migraine (Study 1).
The incidence of “atypical sensations” adverse events (paresthesia, sensation warm/cold) and “pain and other pressure sensations” (chest pain/tightness/pressure/heaviness or neck/throat/jaw pain, tightness, pressure or heaviness) was 2% each in ZECUITY-treated patients, vs. 0% in the control group. Application site bruising was reported in 2 ZECUITY-treated patients (0.9%) vs. no patient in the control group. Subgroup analyses of age (<41 years, >41 years), race (Caucasian, non-Caucasian) and body mass index (BMI) (<25.7 mg/kg²; >25.7 mg/kg²) showed no difference between subgroups for adverse events.

**Skin Irritation Examination**

In Study 1, patients performed their own examination of the TDS application site at 4, 12, and 24 hours post-TDS activation, and daily thereafter until resolution. The median time to “no redness” was 2.6 days for ZECUITY compared with 0.3 day in the control group.

**Application site reaction across clinical studies (Controlled single dose acute migraine study and long term safety studies)**

In the controlled and uncontrolled clinical studies combined (n = 796 unique ZECUITY-treated subjects), the frequency of application site reactions of clinical interest was: discoloration (5%), contact dermatitis (4%), irritation (4%), vesicles (3%), bruising (2%), and erosion (0.4%).

**DRUG INTERACTIONS**

**Ergot-Containing Drugs**

Ergot-containing drugs have been reported to cause prolonged vasospastic reactions. Because these effects may be additive, use of ergotamine-containing or ergot-type medications (like dihydroergotamine or methysergide) and ZECUITY within 24 hours of each other is contraindicated [see Contraindications].

**Monoamine Oxidase-A Inhibitors**

MAO-A inhibitors increase systemic exposure by 2-fold. Therefore, the use of ZECUITY in patients receiving MAO-A inhibitors is contraindicated [see Contraindications].

**Other 5-HT1-A Agonists**

Because their vasospastic effects may be additive, coadministration of ZECUITY and other 5-HT1-agonists (e.g., triptans) within 24 hours of each other is contraindicated.

**Selective Serotonin Reuptake Inhibitors/Serotonin Norepinephrine Reuptake Inhibitors and Serotonin Syndrome**

Cases of serotonin syndrome have been reported during coadministration of triptans and SSRIs or SNRIs, SNRIs, TCAs, and MAO inhibitors [see Warnings and Precautions].

**USE IN SPECIFIC POPULATIONS**

**Pregnancy**

Pregnancy Category C: There are no adequate and well-controlled studies in pregnant women. ZECUITY should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**

It is not known whether sumatriptan is excreted in human milk following transdermal administration. Because many drugs are excreted in human milk, and because of the potential for serious adverse reactions in nursing infants from ZECUITY, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**

Safety and effectiveness in pediatric patients have not been established.

Since clinical data to determine the frequency of serious adverse reactions in pediatric patients who might receive subcutaneous, oral, or intranasal sumatriptan are not presently available, the use of ZECUITY in patients under 18 years of age is not recommended.

**Geriatric Use**

Clinical trials of ZECUITY did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy. A cardiovascular evaluation is recommended for geriatric patients who have other cardiovascular risk factors prior to using ZECUITY [see Warnings and Precautions].

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Brief Summary of ZECUITY Prescribing Information ZEC-001

ZEC-40059 September 2014
ARE YOUR PATIENTS LOOKING FOR A DIFFERENT ROUTE TO MIGRAINE RELIEF?

It’s in the delivery
Coming soon:
a non-oral treatment for migraine
with or without aura in adults

ZECUITY is indicated for the acute treatment of migraine with or without aura in adults.

**Limitations of Use:** Use only if a clear diagnosis of migraine has been established. If a patient has no response to the first migraine attack treated with ZECUITY reconsider the diagnosis of migraine before ZECUITY is administered to treat any subsequent attacks. ZECUITY is not intended for the prevention of migraine attacks.

**IMPORTANT SAFETY INFORMATION**

ZECUITY is contraindicated in patients with:

- Ischemic coronary artery disease (CAD) or coronary artery vasospasm, including Prinzmetal’s angina; or Wolff-Parkinson-White syndrome or other cardiac accessory conduction pathway disorders
- History of stroke, transient ischemic attack (TIA), or history of hemiplegic or basilar migraine; peripheral vascular disease; ischemic bowel disease; or uncontrolled hypertension
- Recent (i.e., within 24 hours) use of ergotamine-containing or ergot-type medication, or another 5-HT\_1 agonist; or concurrent or recent (within 2 weeks) use of a MAO-A inhibitor
- Known hypersensitivity to sumatriptan or components of ZECUITY; severe hepatic impairment; or allergic contact dermatitis to ZECUITY

ZECUITY contains metal parts and must be removed before an MRI procedure.

Use of ZECUITY may lead to allergic contact dermatitis (ACD).

ZECUITY should be discontinued if ACD is suspected. Patients who develop ACD with ZECUITY and require treatment with sumatriptan via other routes should receive their first subsequent dose under close medical supervision.

Other serious adverse events associated with the use of ZECUITY or 5-HT\_1 agonists include: myocardial ischemia/infarction, Prinzmetal’s angina, arrhythmias; chest, throat, neck and/or jaw pain/tightness/pressure; cerebral hemorrhage, subarachnoid hemorrhage, and stroke; peripheral vascular ischemia, gastrointestinal vascular ischemia/infarction, splenic infarction, and Raynaud’s syndrome; medication overuse headache; serotonin syndrome; significant elevation in blood pressure; anaphylactic/anaphylactoid reactions; and seizures.

ZECUITY should not be applied in areas near or over electrically-active implantable or body-worn medical devices.

The most common adverse reactions (≥ 5%) in a controlled single dose study were application site pain, paresthesia, pruritus, warmth, and discomfort.

Please see brief summary of Prescribing Information for ZECUITY on the following pages.