Esteemed Sports Concussion Expert Brian Hainline Named Keynote Speaker for July Conference

Brian Hainline, MD, FAAN, chief medical officer of the National Collegiate Athletic Association (NCAA), senior vice president of the NCAA Sports Science Institute Staff, and chief medical officer and clinical professor in the department of neurology at NYU School of Medicine, will speak about the CARE Consortium during his keynote address at the upcoming AAN Sports Concussion Conference, set for July 8 through 10 at the Hilton Chicago.

For more than 20 years, Hainline has been actively involved in sports medicine, having co-authored *Drugs and the Athlete*, and played a pivotal role in the development of drug testing and education protocols worldwide. He has served on the New York State Athletic Commission, the United States Olympic Committee’s Sports Medicine Committee, and was a founding member of the Executive Committee of the American Academy of Neurology Sports Medicine Section.

AAN Updates BoNT Guidelines

The AAN published “Practice Guideline Update Summary: Botulinum Neurotoxin for the Treatment of Blepharospasm, Cervical Dystonia, Adult Spasticity, and Headache” online ahead of print in *Neurology*® on April 18, 2016.

In clinical practice, botulinum neurotoxin (BoNT) is often the first line of treatment for cervical dystonia and blepharospasm and is one of several therapies available for chronic migraine and spasticity.

This practice guideline update shows that BoNT is generally safe and effective for treating these disorders, but more research is needed to fill in some gaps in knowledge.

Use AAN Webinar to Improve Understanding of Value-based Care

First it’s MU, PQRS, VBM, EHR, FFS, and now its MIPS, CPIA, P4P, APM, and ACOs? It is critical to translate these acronyms into real, understandable features of the changing landscape so you can prepare yourself and your practice. In a new webinar, AAN members who are experts in payment systems and practice management will decipher current and new payer programs so you can make beneficial changes for your practice.

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

May 11, 2016
12:00 p.m. to 1:00 p.m. ET
# NEWS BRIEFS

The AAN and sports concussion guidelines were mentioned twice in a recent congressional hearing investigating concussions in athletics. AAN members Walter J. Koroshetz, MD, FAAN, director of the National Institute of Neurologic Disorders and Stroke at NIH and Brian W. Hainline, MD, FAAN, chief medical officer for the National Collegiate Athletic Association (NCAA), were asked to participate in the forum sponsored by the House Energy & Commerce Committee.

The Centers for Medicare and Medicaid Services unveiled an anticipated Medicare Part B drug demonstration to test new approaches to paying for prescription drugs administered in doctors’ offices. The AAN is reviewing the proposal and its potential impact on neurologists, especially those at infusion centers.

The AAN has selected the winning videos for the Neuroscience Is...™ Cool video contest. Canadian students were asked to grab their phones and make up a one-minute video telling us why they think neuroscience is cool. Delila Gama is the winner in the 13-15 age category; Joseph Falzone is the winner in the 16–18 age category. View all video entries and the winning selections at Youtube.com/user/AANChannel.
President’s Column

Seeking to Train New Neurology Leaders: Is It Your Time to Step Up?

The many challenges in today’s health care environment create a special need for great leadership. While the Academy has long recognized that we need to cultivate leaders to build neurology’s future, we have recently renewed and expanded on this commitment with the introduction of the AAN Leadership Program, an initiative launched by the Leadership Development Committee.

The committee reviewed current leadership options available to members, and identified gaps and programs to fill those gaps. In addition, we’ve introduced a new brand mark to associate all programs with the same standard of quality reflecting our commitment to advance the leadership potential of members across any career stage.

The AAN is eager to help provide the training that is often necessary to help you discover and nurture these skills, no matter what career stage you might be in. The following programs are now a part of the prestigious new AAN Leadership suite of programs.

Our newest 10-month program is Transforming Leaders, an elite program that will help mid-career members enhance their talents and move their careers to the next level. The program provides customized individual leadership development training, one-on-one coaching, and mentoring opportunities with AAN leadership and member neurologists. Participants will engage in a self-guided project during the first four months of the program, a group project during the second portion of the program, and final presentations to the AAN Board of Directors in June 2017. If you are more than 10 years out of residency, wish to learn more, and would like to apply online by the July 1, 2016, deadline, please visit AAN.com/view/TransformingLeaders.

The Palatucci Advocacy Leadership Forum has trained 410 members to be effective advocates for neurology at state and national levels, as well as within their own communities or institutions. Applications for the 2017 program will open this fall.

Based on the popular conference course, a Women in Leadership program will be introduced later this year to enhance the leadership potential of a select group of women via a unique 10-month training and mentorship program.

Emerging Leaders is a six-month program we launched in 2012 for members who are 10 or less years out of residency. Participants receive leadership development training, one-on-one mentoring, media training, and participate in a collaborative, in-depth group project. We will begin seeking applications in April 2017.

Continued on page 9 ▶
Meet Your Leader

Gregory D. Cascino, MD, FAAN, FANA, FACNS

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

Gregory D. Cascino, MD, FAAN, FANA, FACNS, is the Whitney MacMillan, Jr., Professor of Neuroscience, Mayo Clinic College of Medicine and Enterprise Director of Epilepsy at the Mayo Clinic in Rochester, MN. He served in many leadership positions within the AAN before joining the Board in 2011, including chair of the Section on Epilepsy, chair of the Membership Committee, and member of the Scientific Program Subcommittee and Nominations Committee. Cascino currently serves on the Executive Committee of the Section on Epilepsy, as chair of the Member Engagement Committee, as an associate editor of Neurology®, and as a member of the Academic Work Group.

What moved you to join the Board of Directors? What experiences and viewpoints do you bring to this role?

I was motivated to be considered for the Board of Directors because of my passion to support the needs and concerns of the members of this organization. The AAN is pivotal to demonstrate the importance and value of neurologists through all aspects of a career. The fundamental activities of the AAN involving education, clinical practice, research, and advocacy are essential to the needs of neurologists. During my role as chair of the Membership Committee, I appreciated the diversity, aspirations, and concerns of our more than 30,000 AAN members. I “see” the role of the Board quite differently having been involved with membership activities in two leadership positions as a committee chair.

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

An important misperception of the AAN is that the value of membership is limited to a subscription to the “green journal.” Individuals often comment that access to the journals through their institutions has made membership “unnecessary.” The activities of the AAN are not limited to publications. Another important issue is the common impression that a subspecialty society “replaces” the need for AAN membership. This is also incorrect because the subspecialty organizations do not have the resources or personnel to compare with the diverse and broad activities of the AAN, including advocacy to represent the field of neurology.

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

The educational mission of the AAN has a tremendous effect on all our members beginning with students to the most senior and accomplished neurologists. The educational and scientific programs available at the Annual Meeting, Fall Conference, and Breakthroughs in Neurology conference remain the cornerstone of the development of a neurology career. Importantly, educational activities go well beyond face-to-face meetings and include the incomparable Continuum, published guidelines and practice parameters, online continuing medical education programs, and webinars.

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

The success of any professional organization can only be measured by the career satisfaction and achievements of its members. The recruitment of new members, number of active members, and retention of individuals are important in determining the viability of an organization. However, the success of the AAN and the Board of Directors must go beyond the simple metrics of membership enrollment. The diversity in the AAN indicates that success cannot be judged by only one factor. “Success” may be defined differently for a clinical neurologist in solo practice, a researcher in an academic institution, or a business administrator. The common theme for all our members is a Board of Directors that listens and responds to their individual concerns. Of course, the Board empathizes with the membership because we face the same day-to-day challenges.

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

This is a very common issue because of the number of “hats” we all wear at work and at home. Some days I do better at dealing with the challenges of having multiple personal and professional responsibilities at the same time. I attempt to prioritize the concerns, “what needs to be done NOW,” and set realistic goals. The demands can build up because of patient care, education of students and trainees, research projects, manuscript reviews, and medical documentation. I have become used to being a “little late” on submitting a book chapter or getting back to a research coordinator with forms to be completed. I am still learning to try and say “No” to some commitments, e.g., another book chapter, when the list of “to do” is growing. Teresa, my spouse for 36 years, and I have enjoyed traveling since our three children are now grown up. Sailing the high seas on a cruise ship without mobile phones or email is therapeutic once per year. Finally, I try and “reserve” a part of each day for myself, my personal “time out,” that may include a walk during lunch, bringing my dog to a park after work, trying to hit a golf ball (indoor golf center only during winter in Rochester), or going to the health club.
Neurologists Sought to Participate in Dementia Care Model

Neurologists know that caring for dementia patients is incredibly stressful for families and caregivers. Some 15 million people in the United States care for family and friends with this chronic disease. These caregivers often neglect their own needs and health, and more than a third report depression symptoms.

This dire situation has led to the development of the Dementia Care Ecosystem by the University of California–San Francisco and the University of Nebraska Medical Center. They were recipients of a three-year $10 million grant from the Center for Medicare & Medicaid Innovation in 2014 to create and demonstrate a new web-based model of dementia care specifically oriented to families and caregivers.

The new ecosystem has been designed to provide consultants, called “Care Team Navigators,” to patients and their families as well as online education resources developed over the last decade by the UCSF Memory and Aging Center (MAC). The Care Team Navigators are backed by a clinical team and together they provide personalized medication guidance, caregiver support, and guidance around planning ahead for medical, financial, and legal decisions. Furthermore, a subset of patients will be remotely monitored by the team with smart phones, smart watches, and home sensors.

AAN member Bruce L. Miller, MD, FAAN, is director of the MAC. “The Dementia Care Ecosystem will not replace clinicians, but rather bring them closer to patients and their families. Our ecosystem will have information, experience, and empathy readily accessible to caregivers who may feel overwhelmed. Typically, these people have a hard time getting through to anyone in the medical system between office visits.”

“Our hope is this is going to radically improve the way dementia patients are cared for,” said Katherine Possin, PhD, who is an assistant professor of neuropsychology at UCSF. “We hope we’ll show this works, and that it can be adopted nationwide.”

Some patients in the study will have an added level of technology-based care. They will use smart phones, watches, and sensors placed inside their home to record their activity levels, count the number of steps they take, and measure how far they range from home. The goal is to detect behavior changes that could signal the onset of a health problem, like being awake all night, staying in bed all day, or going to the bathroom more frequently than usual. This information will provide caregivers with additional insights into the patients’ health.

The demonstration project is a third of the way through the study, and has enrolled 430 caregiver participants and 430 patients with dementia. They take people with any type of Medicare or Medicaid, and one-quarter of the population is on Medicare Advantage. The team hopes for 2,100 enrollees a year from now. In the meantime, results are being analyzed—the primary caregiver satisfaction rate is 84 percent—and new matters are being addressed.

The data collected through these early demonstrations will help inform future care models, so they’re critically important. With the advent of MACRA and payment reform, Possin said the center is exploring what the payment model for this type of care ecosystem would look like. One possibility is bundled payments, probably in an accountable care organization (ACO) with the group assuming risk for patients. They also are looking into what types of chronic care management codes could apply for dementia in a fee-for-service environment.

“We are eager to find other health care systems to partner with us during the trial,” said Possin. “We would like to find groups willing to study the ecosystem during the trial and then sustain it. We’re open to small or large practices.”

For more information about the program or to participate, contact Possin at Katherine.possin@ucsf.edu or visit their website at tiny.ucsf.edu/CareEcosystem to learn more.

The project described was supported by Grant Number 1C1CMS331346 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the US Department of Health and Human Services or any of its agencies.

Bruce L. Miller, MD, FAAN
Katherine Possin, PhD

Dementia Care Ecosystem Team
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. Interviews based on articles from *Neurology*® Clinical Practice, *Neurology*® Genetics, and *Neurology*® Neuroimmunology & Neuroinflammation are excluded from the CME program.

Available by May 1
- *Neurology*: Mid-life exercise blood pressure, heart rate and fitness relate to brain volume two decades later
  Jeffrey M. Burns, MD, and Nicole L. Spartano, PhD
- *Neurology*: Randomized, placebo-controlled trials of dichlorphenamide in periodic paralysis
  Ted M. Burns, MD, and Valerie A. Sansone, MD
- *Neurology*: Standardized EEG interpretation accurately predicts prognosis after cardiac arrest
  Jennifer E. Fugate, DO, and Tobias Cronberg, MD, PhD
- *Neurology*: The association between hospitalization and care after transient attack or minor stroke
  Andrew M. Southerland, MD, MSc, and Moira Kapral, MD, MSc, FRCPC

Use AAN Webinar to Improve Understanding of Value-based Care
*Continued from cover*

**Deadline to Register:** May 10
**Directors:** Eric M. Cheng, MD, MS, FAAN, and David A. Evans, MBA

- Apply changes in your practice now to improve reimbursement for current performance program
- Differentiate between the current CMS incentive programs payment systems and the new Merit-based Incentive Payment System (MIPS)
- Understand the new principle of clinical practice improvement activities as part of the composite score that comprises MIPS
- Identify resources provided to members of AAN for compliance in some of the measures, including the Axon Registry™

**Enjoy New Reduced 2016 Member Pricing!**
- AAN members pay 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
- If you have scheduling conflicts, registration gives you access for one year to the recorded webinar if you miss the live event
- 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.

Visit AAN.com/view/pmw16 for more information or to register.

**Coming in June**
Aarti Sarwal, MD, a 2015 graduate of the AAN’s Palatucci Advocacy Leadership Forum (PALF), is medical director of the neurocritical care unit at Wake Forest Baptist Medical Center in Winston-Salem, NC. She quickly applied her newly learned advocacy skills to help promote an innovative $16.5 million state-of-the-art neurocritical care unit for patients with acute neurologic injuries at Wake Forest Baptist Medical Center.

“We built our new 24-bed neuro ICU over the last year with patient and family feedback with many features focused on them,” Sarwal explained. “We planned this unit over two years with all clinical providers closely involved in requesting features, along with end-user feedback incorporating the latest available ICU technology like mobility lifts, booms, and copper-coated surfaces for infection prevention. The advocacy techniques I learned at PALF proved helpful in convincing our institutional leadership to make decisions that allowed us to implement many patient- and family-centered features that were new to the institute’s culture.”

Moving into the new ICU was going to be a huge cultural change, according to Sarwal, “that will lead to new nursing and physician workflows, triage plans, and contingency plans to be developed and instituted. The action planning seminar at PALF was the foundation in planning this move. Using my PALF training, we developed a map of safety and quality measures to be taken prior to the move outlining objectives, resources, success measures and timelines that needed to be accomplished at each step.”

While the facilities were still under construction, Sarwal and AAN member Ihtsham Haq, MD, a graduate of the Academy’s Emerging Leader Forum, invited US Rep. Virginia Foxx (R-NC) to visit. Foxx chairs the House Education and Workforce and Higher Education and Workforce Training Subcommittee and sits on the Health, Employment, Labor, and Pensions Subcommittee. “We introduced her to the work of neurologists by meeting various subspecialists and showed her how important neurology is to our community, with a focus on how we’re using information in new ways to help our patients including patient and family centered in the neurocritical care unit.”

Sarwal and Haq also used this visit to ask Foxx to support undergraduate medical education and graduate medical education. “This is an important component to strengthening North Carolina’s physician workforce supply. We encouraged her to sponsor The Resident Physician Shortage Reduction Act of 2015 (HR 2124). The AAN staff was very helpful in advising us when Rep. Foxx visited us. This was her first time visiting neurology at Wake Forest Baptist. The staff suggested we not assume anything and introduce Rep. Foxx to what the neurologists do. We discussed how we’re using information in new ways to help our patients, including our patient- and family-centered focus in the neurocritical care unit. This helped us concentrate her attention on neurology advocacy.”

Sarwal also employed her Forum exercises in strategic communications and interview skills to prepare her for the actual media interviews and prioritizing key points to highlight. “Media training was instrumental in teaching me the power of a 10-second soundbite and learning to talk in layman’s language when communicating issues regarding the complicated clinical situations surrounding neurocritical care patients.”

Her efforts were well rewarded. “We were featured in local print and television media when the new ICU opened,” said Sarwal. “We held an open house for area physicians, and many attended and asked us for write-ups of details of specific features we incorporated. I would be happy to share this with other AAN members thinking of upgrading, renovating, or building their ICUs and incorporating patient-centric features.”

For more information on the new neurocritical care unit, visit WakeHealth.edu/Neurosciences/Neurosciences-Critical-Care-Unit or contact Sarwal at asarwal@wakehealth.edu.
Palatucci Graduate New President-elect of Medical Society

Raghav Govindarajan, MD, a 2012 graduate of the AAN’s Palatucci Advocacy Leadership Forum, was elected as the president-elect of the Boone County Medical Society in Missouri. Govindarajan is the first neurologist to hold this position in the 100-year existence of the society.

“The Palatucci Forum taught me the ‘4 Ps’ of success: passion, persistence, pointed/pragmatic action plan, and partnering with others,” Govindarajan said. “I have since used this not just in advocacy work but in all aspects of my life and career. Above all, the forum gave me confidence and self-belief in advocating for neurology at the grassroots level, especially through sound bite training and the mock media interviews. To further advocate for our patients and our cherished profession, I stood for and won the nomination.”

For more information on the Palatucci Advocacy Leadership Program, visit AAN.com/view/2016palf.

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.

In April, the AAN announced formal participation in the National Coalition on Health Care’s Campaign for Sustainable Rx Pricing (CSRxP). The AAN is dedicated to supporting neurologists in providing the highest quality care available for their patients and that includes finding ways to help their patients maintain access to the best medications. By becoming part of the conversation with the CSRxP, our goal is to have an opportunity to influence drug pricing in a positive way and represent what is best for our members and their patients.
AAN Updates BoNT Guidelines

Unlike the approach taken to review the evidence in the 2008 guidelines, this guideline update assessed each formulation separately for each indication. There are important differences between BoNT preparations, including their purification and manufacturing process, biologic activities, formulations, potency, and other properties. Therefore, the different products are not interchangeable. For some indications, the evidence levels vary by formulation.

One change from the AAN’s 2008 guidelines relates to the evidence for chronic migraine that shows that onabotulinumtoxin type A can increase the number of headache-free days. The guideline update found strong evidence of an effect, but the magnitude of the difference in efficacy compared with placebo is small.

“For neurologists, rehabilitation specialists and other medical practitioners, including those in the primary care setting, it is important to have these new data to support BoNT as a potential treatment for the indications studied. This is particularly true for chronic migraine because the recommendations have substantially changed since the prior guidelines were published in 2008,” said David M. Simpson, MD, FAAN, lead guideline author. He added, “Because of the expanded clinical trial results and FDA approvals for the several BoNT formulations, it is important that clinicians understand the relative data sets supporting the use of the individual drugs, which should be helpful in employing the drugs in clinical practice. Our updated guideline provides these data.”

The guideline was endorsed by the American Association of Neuromuscular & Electrodiagnostic Medicines and the American Society of Plastic Surgeons.

Read the guideline and access PDF summaries for clinicians and patients, a slide presentation set, and a payment policy perspectives article on AAN.com. For more information, contact Julie Cox at jcox@aan.com or (612) 928-6069.

David M. Simpson, MD, FAAN

President’s Column

Seeking to Train New Neurology Leaders: Is It Your Time to Step Up?

Continued from page 3

Our commitment to helping to nurture the interests of young minority students in our profession of neurology began many years ago with our Minority Scholarships. But we recognized we must do more. Now in its second year, our Diversity Leadership program is responding to the needs of members of underrepresented groups who seek to develop their leadership abilities so we can have much wider and richer representation of all voices, viewpoints, and experiences. New applications will be accepted in November 2016.

But the Academy’s leadership needs do not stop there. As the AAN is committed to assisting members in all phases of their careers, we have established additional training programs.

The Enhanced Resident Scholarship is designed to provide in-depth opportunities for residents to engage with the field of neurology and the AAN and to build leadership potential. Fourth-year residents, nominated by their program directors, receive a scholarship to attend the Annual Meeting along with opportunities to acquire and enhance key skills while being mentored by established AAN leaders.

Leadership University now includes the many leadership courses we provide at our Annual Meeting and regional conferences, either full-day or half-day programs. The courses are focused on building select skills to enhance leadership abilities. These have included such programs as:

- Women in Leadership
- Between Mars and Venus: How Great Leadership Adopts Traits from the Best of Both Genders
- Improving Your Leadership Skills: A Practical Approach
- The Most Important Tool in Your Black Bag: Gallup StrengthsFinder™ Assessment

I am very happy with the work of the Leadership Development Committee to analyze, restructure, and pull these programs together under one unifying brand. The Academy has made a deep commitment to helping members excel at every career stage and make these opportunities available to you. Now, it’s up to you to learn more and seize the moment if you feel you have what it takes to dedicate yourself to expanding your skills, knowledge, and vision to join the ranks of AAN leaders, both within our organization and within yours. I encourage you to learn more about AAN leadership opportunities at AAN.com/view/Lead.

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology
tcascino@aan.com
New NeuroLearn Patient Safety Course, Free to AAN Members

A new Patient Safety course will soon be available as part of NeuroLearnSM, the AAN’s exclusive suite of online education courses. The Patient Safety course is designed to help AAN members address the ABPN’s recently implemented, one-time requirement of diplomates to complete an approved patient safety course within three years prior to their board certification/recertification, or in their first C-MOC block. The new ABPN requirement was implemented in January 2016.

Available free to members as an exclusive benefit of AAN membership, the course is designed with convenience in mind—it may be taken on a desktop or tablet, from virtually anywhere at your own time and pace, and completed in approximately 1–1.5 hours. Upon successful completion, NeuroLearn Patient Safety awards 2 Self-assessment CME credits.

The course is comprised of 10 separate elements which the learner can work through in any order. All elements include audio and visual reinforcements and a formative assessment, and some incorporate opportunities for reflection, strategy, and implementation planning. In order to receive CME credit, you must successfully complete one summative assessment and an evaluation.

Course topics include:

- Increasing Patient Safety Awareness and Practice Among Clinicians and Staff
- Methods for Measuring Performance and Clinical Outcomes
- The Role of Health Information Technology in Patient Safety
- Reducing Medication Errors
- Advancing Patient Safety Through Systems Thinking and Design
- Establishing a Patient Safety Culture
- Safety Enhancing Technology

Free AAN member access to online education programs is limited to one course at a time. Medical Students and Nurse Practitioner/Physician Assistant members at the lower dues rate are not eligible for free access.

Second Edition of NeuroLearn: The Brachial Plexus Available

A second edition of NeuroLearn’s The Brachial Plexus course is now available and free to AAN members. Led by Daniel L. Menkes, MD, FAAN, the new edition allows you to:

- Earn 1.0 CME credits
- Address the core competencies of patient care and medical knowledge
- Identify the anatomy of the brachial plexus
- State the purpose of the brachial plexus structure
- Recognize and label the components that comprise the brachial plexus
- Diagnose mononeuropathy, plexopathy, and radiculopathy
- Recognize the use of electrodiagnostic studies as a means of confirming clinical diagnosis

Visit AAN.com/view/NeuroLearn to learn more.

Reminder: May 2 Is Deadline to Submit Online Evaluations for Annual Meeting CME

May 2 is the deadline to submit your evaluation forms to receive CME for the 2016 Annual Meeting. Forms may be completed online at AAN.com/view/CME or through the Annual Meeting mobile app at AAN.com/view/app.
QUIETING MS Quietly*

for your patients with relapsing MS

Once-daily
AUBAGIO®
(teriflunomide) 14 mg tablets

AUBAGIO is available in 14 mg and 7 mg tablets.

* AUBAGIO is effective across key measures of disease activity: sustained disability progression (14 mg only), annualized relapse rate, and MRI activity. Overall discontinuation rates due to adverse events were 12.5% with AUBAGIO 14 mg, 11.2% with AUBAGIO 7 mg, and 7.5% with placebo, and treatment discontinuation rates due to common adverse events were ≤3.3% in the pooled clinical trials.1,2

MS = multiple sclerosis.

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

INDICATION
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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 (eg, 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
A proven approach to quieting* relapsing MS

2 trials impacting disability progression

- AUBAGIO 14 mg is the only oral RMS 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 trial1
- Sustained disability progression was defined as at least a 1-point increase from baseline Expanded Disability Status Scale (EDSS) score ≤5.5 (or at least a 0.5-point increase for those with a baseline EDSS score >5.5) sustained for at least 12 weeks1

1 daily tablet

- AUBAGIO is one tablet, once a day1
- Health care professionals should run certain tests before prescribing AUBAGIO and should monitor patient liver enzyme levels monthly for the first 6 months1

reported with AUBAGIO. Obtain a complete blood cell 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.

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.

TEMSEO: 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

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

AUBAGIO is available in 14 mg and 7 mg tablets.
AUBAGIO® (teriflunomide) and MS One to One® may help your patients manage their RMS

Getting started: the AUBAGIO Start form is both a prescription for AUBAGIO and enrollment for support offered by MS One to One.

AUBAGIO is effective across key measures of disease activity: sustained disability progression (14 mg only), annualized relapse rate, and MRI activity. Overall discontinuation rates due to adverse events were 12.5% with AUBAGIO 14 mg, 11.2% with AUBAGIO 7 mg, and 7.5% with placebo, and treatment discontinuation rates due to common adverse events were ≤3.3% in the pooled clinical trials.\(^1,\)\(^2\)

RMS=relapsing forms of MS.

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.

AUBAGIO®
(teriflunomide) tablets, for oral use

Brief Summary of Prescribing Information

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 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 cholestyramine 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 must be avoided during AUBAGIO therapy 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 (5.4)].
• Check blood pressure before start of AUBAGIO treatment and periodically thereafter [see Warnings and Precautions (5.7)].

4 CONTRAINDICATIONS

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 woman who is pregnant. 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 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 childbearing 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 and Reticuloendothelial System
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 alanine aminotransferase (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. Teriflunomide plasma concentrations 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)].

5.2 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 the physician immediately for pregnancy testing and, if possible, to stop taking the drug. 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 includes verification of teriflunomide plasma concentration 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). 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)].

AUBAGIO facilitates AUBAGIO treatment who wish to become pregnant must discontinue AUBAGIO and undergo an accelerated elimination procedure, which includes verification of teriflunomide plasma concentration less than 0.02 mg/L (0.02 mcg/mL). If AUBAGIO-induced liver injury is unlikely because some other probable cause has been found, resumption of AUBAGIO therapy may be considered.

5.4 Bone Marrow Effects/Immunosuppression Potential/Infections

White Blood Cell (WBC) count decrease
A decrease in white blood cell (WBC) count of approximately 15% (mainly neutrophils and lymphocytes) and in platelet count of approximately 10% was observed in placebo-controlled trials with 7 mg and 14 mg of AUBAGIO compared to baseline. The decrease in mean WBC count occurred during the first 6 weeks and WBC count remained low during treatment. In placebo-controlled studies, neutrophil count < 1.5 × 10^9/L was observed in 12% and 13% of patients receiving AUBAGIO 7 mg and 14 mg, respectively, compared with 7% of patients receiving placebo; lymphocyte count < 0.8 × 10^9/L was observed in 10% and 12% of patients.
receiving AUBAGIO 7 mg and 14 mg, respectively, compared with 6% of patients receiving placebo. No cases of serious pancytopenia were reported in premarketing clinical trials of AUBAGIO but rare cases of pancytopenia, agranulocytosis, and thrombocytopenia have been reported in the postmarketing setting with leflunomide. A similar risk would be expected for AUBAGIO [see Clinical Pharmacology (12.3) in the full prescribing information]. Obtain a complete blood cell count (CBC) within 6 months of initiating treatment with AUBAGIO. Further monitoring should be based on signs and symptoms suggestive of bone marrow suppression.

Risk of Infection / Tuberculosis Screening

Patients with active or recent infections should not start treatment until the infection is resolved. If a patient develops a serious infection consider suspending treatment with AUBAGIO and using an accelerated elimination procedure. Reassess the benefits and risks prior to resumption of therapy. Instruct patients receiving AUBAGIO to report symptoms of infections to a physician. AUBAGIO is not recommended for patients with severe immunodeficiency, bone marrow disease, or severe, uncontrolled infections. Medications like AUBAGIO that have immunosuppression potential may cause patients to be more susceptible to infections, including opportunistic infections.

In placebo-controlled studies of AUBAGIO, no overall increase in the risk of serious infections was observed with AUBAGIO 7 mg (2.2%) or 14 mg (2.7%) compared to placebo (2.2%). However, one fatal case of klebsiella pneumonia sepsis occurred in a patient taking AUBAGIO 14 mg for 1.7 years. Fatal infections have been reported in the post-marketing setting in patients receiving leflunomide, especially Pneumocystis jiroveci pneumonia and aspergillosis. Most of the reports were confounded by concomitant immunosuppressant therapy and/or comorbid illness which, in addition to rheumatoid disease, may predispose patients to infection.

In clinical studies with AUBAGIO, cytomegalovirus hepatitis reactivation has been observed.

In clinical studies with AUBAGIO, cases of tuberculosis have been observed. Prior to initiating AUBAGIO, screen patients for latent tuberculosis infection with a tuberculin skin test or with a blood test for mycobacterium tuberculosis. AUBAGIO has not been studied in patients with a positive tuberculosis screen, 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.

Malignancy

The risk of malignancy, particularly lymphoproliferative disorders, is increased with the use of some immunomodulating medications. There is a potential for immunosuppression with AUBAGIO. No apparent increase in the incidence of malignancies and lymphoproliferative disorders was reported in the AUBAGIO clinical trials, but larger and longer-term studies would be needed to determine whether there is an increased risk of malignancy or lymphoproliferative disorders with 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 3.0% (4 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% (6 patients) with confirmed peripheral neuropathy (3 patients receiving AUBAGIO 7 mg and 5 patients receiving AUBAGIO 14 mg). Five of these patients recovered following treatment 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 neurotic 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 performing an accelerated elimination procedure [see Warnings and Precautions (5.5)].

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 was reported with use of 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 (5.5)].

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, and -0.6 mmHg for placebo. The change 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 during treatment.

5.8 Respiratory Effects

Intestinal lung disease 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].

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.

<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>Increase in Alanine aminotransferase</td>
<td>13%</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>13%</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Alopecia</td>
<td>10%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Nausea</td>
<td>8%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Paresthesia</td>
<td>8%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>8%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>4%</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Cardiovascular deaths

Four cardiovascular deaths, including three sudden deaths, and one myocardial infarction in a patient with a history of hyperlipidemia and hypertension were reported among approximately 2600 patients exposed to AUBAGIO in the premarketing database. These cardiovascular deaths occurred during uncontrolled extensions, one to nine years after initiation of treatment. A relationship between AUBAGIO and cardiovascular death has not been established.

Acute Renal Failure

In placebo-controlled studies, creatinine values increased more than 100% over baseline in 8/1045 (0.8%) patients in the 7 mg AUBAGIO group and 6/1002 (0.6%) patients in the 14 mg AUBAGIO group versus 4/997 (0.4%) patients in the placebo group. Some elevations were accompanied by hyperkalemia. AUBAGIO may cause acute uric acid nephropathy with transient acute renal failure because AUBAGIO increases renal uric acid clearance.

Hyphosphatemia

In clinical trials, 18% of AUBAGIO-treated patients had hyphosphatemia with serum phosphorus levels of at least 0.6 mmol/L, compared to 7% of placebo-treated patients.
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., paclitaxel, 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
Coadministration 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., alosol, duloxetine, theophylline) 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 transporter 3 (OAT3) substrates
Teriflunomide inhibits the activity of OAT3 in vivo. In patients taking AUBAGIO, exposure of drugs which are OAT3 substrates (e.g., efalizumab, etomoxir, folinic acid, penicillin G, ketoprofen, furosamide, 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 B1 and B3 (OATP1B1/B3) substrates
Teriflunomide inhibits the activity of BCRP and OATP1B1/B3 in vivo. For a patient taking AUBAGIO, the dose of rosuvastatin should not exceed 10 mg 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, pravastatin, repaglinide, 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 abnormalities, 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 development (0.10 mg/kg/day) was less than that 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 male-mediated fetal toxicity 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 teriflunomide (AUBAGIO) 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
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 enrol themselves, by calling 1-800-745-4447, option 3.

8.3 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.

8.4 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)].

Genzyme Corporation
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A SANOFI COMPANY

October 2014a

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Revised: October 2014a
Multiple sclerosis (MS) and other demyelinating diseases is the latest topic covered in the Continuum® Audio series. The first two hours are now available for you to hear from experts on the latest diagnosis and treatment advances, and the convenient format allows you to listen from anywhere, anytime.

“The past decade has seen major advances in the diagnosis and treatment of MS and related demyelinating disorders,” said associate editor and host of the series Ralph F. Józefowicz, MD, FAAN, who is a professor of neurology and medicine and associate chair for education in the department of neurology at the University of Rochester. “This Continuum Audio series will provide the practicing neurologist with key information about these disorders related to patient management. Specific topics include new approaches to the diagnosis and treatment of MS, discontinuing disease-modifying drugs, incidental MR lesions, NMO spectrum disorder, and pregnancy and MS. Special consideration will be given to pediatric demyelinating disorders.”

The first two hours of the series are currently available; the second two hours will be available in June.

Hour 1:
- Stephen C. Krieger, MD / New Approaches to the Diagnosis, Clinical Course, and Goals of Therapy in Multiple Sclerosis and Related Disorders
- David E. Jones, MD / Early Relapsing Multiple Sclerosis
- Robert J. Fox, MD, FAAN / Progressive Multiple Sclerosis

Hour 2:
- Regina Radner Berkovich, MD, PhD / Acute Multiple Sclerosis Relapses
- Mark S. Freedman, MSc, MD, FAAN, FRCPC / Severe, Highly Active, or Aggressive Multiple Sclerosis
- Aaron E. Miller, MD, FAAN / Switching or Discontinuing Disease-Modifying Therapies for Multiple Sclerosis
- Ludo J. Vanopdenbosch, MD, FAAN / Palliative Care in Multiple Sclerosis

Hour 3:
- Darin T. Okuda, MD, FAAN, FANA / Incidental Lesions Suggesting Multiple Sclerosis
- Ilana Katz Sand, MD / Neuromyelitis Optica Spectrum Disorders
- Patricia K. Coyle, MD, FAAN / Symptom Management and Lifestyle Modifications in Multiple Sclerosis

Hour 4:
- Michelle Fabian, MD / Pregnancy in the Setting of Multiple Sclerosis
- Sona Narula, MD / Pediatric Demyelination
- Adeline Vanderver, MD / Genetic Leukoencephalopathies in Adults
- Lily Jung Henson, MD, MMM, FAAN / Health Literacy and Outcomes in Multiple Sclerosis

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.
Esteemed Sports Concussion Expert Brian Hainline Named Keynote Speaker for July Conference

Neurology Section, where he currently serves as vice chair. Hainline has played a pivotal role in the development of health and safety standards in tennis, both nationally and internationally. He was chief medical officer of the US Open Tennis Championships for 16 years, and then served as chief medical officer of the United States Tennis Association before moving to the NCAA. He is chair of the International Tennis Federation Sport Science and Medicine Commission, and oversaw the rollout of international wheelchair tennis competition, for which he wrote the rules of eligibility for both para- and quad-tennis.

The Sports Concussion Conference is designed to be a multidisciplinary conference grounded in the latest evidence-based science, but focused on clinical diagnosis and management. The conference will engage participants in discussions about the latest information in the world of sports concussion through a variety of formats, including hands-on workshops and debates. Attendees can expect to:

- Apply the latest diagnosis and treatment of concussion protocols
- Understand post-concussion syndrome and how the field is moving beyond complete rest and toward more active rehab
- Apply skills to the high school, collegiate, or professional arenas
- Better understand the continuum of the concussion model from prevention to monitoring to recovery
- Earn up to 20 CME credits

Save Up to $200 When You Register by June 14
Money-saving early registration discounts end June 14. Don’t miss your chance to save on admission to what is poised to be the go-to-meeting for all disciplines involved in the prevention, diagnosis, and treatment of sports concussion, including neurologists, athletic trainers, and other medical professionals such as family physicians, pediatricians, physical therapists, physician assistants, and nurses. Visit AAN.com/view/ConcussionConference to learn more and to secure your spot today.

REMINDER: May 9 Abstracts Submission Deadline Approaching
May 9 is the deadline submit abstracts on a variety of topics related to sports concussion, including treatment, prevention, and education for presentation in a poster discussion session or during general poster sessions at the 2016 AAN Sports Concussion Conference. Visit AAN.com/view/ConcussionConference to submit or contact science@aan.com for more information.

AAN and Sports Concussion Conference Approved by Board of Certification for the Athletic Trainer Provider

The AAN and the Sports Concussion Conference have recently been approved by the Board of Certification for the Athletic Trainer (BOC) as an official BOC Provider for Category A continuing education units (CEUs) for Athletic Trainers.
Research & Awards

Scholarships Enable International Physicians to Attend Annual Meeting

The AAN provided scholarships to these 13 international physicians to attend the 2016 Annual Meeting.

Lucas Alessandro, MD
Buenos Aires, Argentina
Andrea Barp, MD
Padova, Italy
Leyla Baysal Kirac, MD
Istanbul, Turkey
Carlos Camara-Lemarroy, MD
Monterrey, Mexico
Valentina Damato, MD
Rome, Italy
Milena de Albuquerque, MD
Campinas, Brazil
Ranhel De Roxas, MD
Batangas, Philippines
Mauricio Farez, MD, MPH
Buenos Aires, Argentina
Inigo Gabilondo Cuellar, MD, PhD
Bilbao, Spain
Jyh Yung Hor, MD, MMed, MRCP
Penang, Malaysia
Anne-Katrin Proebstel, MD
Basel, Switzerland
Roopa Rajan, MD
Trivandrum, India
Agnes van Sonderen, MD
The Hague, The Netherlands

“I am pleased that the AAN can honor so many young neurologists from around the globe with the International Scholarship Award, recognizing their excellent work furthering neurological practice and research, as also shown by the quality of the abstracts they submitted for the Annual Meeting,” said Massimo Pandolfo, MD, FAAN, chair of the International Subcommittee. “Some awardees live and work in resource-limited conditions, which makes their accomplishments all the more remarkable. The AAN is proud to support these young and bright colleagues, who enrich our Annual Meeting experience.”

Set Yourself Apart

Get the recognition you deserve. Add the esteemed Fellow of the AAN (FAAN) designation to your already impressive credentials.

Learn how at AAN.com/view/FAAN.
Helping Create the National Voice for Brain Health

The American Brain Foundation’s quest to become the national voice for brain health will require the support of many advocates. Longstanding Foundation donors Timothy A. Pedley, MD, FAAN, and Barbara S. Koppel, MD, FAAN, are furthering this goal with a generous donation toward the organization’s strategic planning process.

“We are longtime supporters of the American Brain Foundation and especially of its new direction to become the national voice for brain health and also a national focus for researchers, donors, and patient organizations working collaboratively to defeat brain disease,” said Pedley, past president of the AAN who served on the Foundation Board from 2011 to 2014. “Because we believe strongly in this new direction, we want to do what we can to help assure the Foundation’s success.”

Koppel said she is excited about the American Brain Foundation’s plan to broaden its appeal of support to the public. “The American Brain Foundation has been supported almost exclusively by neurologists until now,” she said. “The one in six people suffering from a disease of the nervous system, and their concerned family members, should obviously be even more interested in any action that will help their condition, so they should appreciate the opportunity to join this fight. To this end, we are pleased that the Foundation has already begun diversifying its board to include non-neurologist members of the public.”

Pedley said, “If we are to raise the amounts of money necessary to cure diseases like dementia, stroke, brain cancer and ALS, we need to involve everyone who has a relative with a brain disease, or knows someone who has a brain disease, in this fight. We are confident that continuing research will eventually lead to prevention of brain diseases or to cures, but the cost of an expanded and sustained research effort—something akin to the Manhattan Project—will not be cheap. We believe that it would be tragic if we fail for lack of money. And that’s where the American Brain Foundation comes in.”

The Foundation’s goal of funding innovative, higher risk medical research also resonates with Pedley and Koppel. “The Foundation is committed to continued funding of the most promising early-career investigators, but also to increased investment in higher risk research projects,” Pedley said.

The couple also attests to the Foundation’s aim to help the public make the connection between seemingly unconnected brain diseases. “The American Brain Foundation believes—as do we—that finding a cure for one brain disease will likely accelerate success in finding cures for others. We see this as a great opportunity for AAN members to direct patients, family members, caregivers, and community philanthropists—no matter what their specific disease concern may be—to an organization with a broad perspective and a vision of “cure brain disease”—all brain diseases.”

To make a donation to the American Brain Foundation, visit AmericanBrainFoundation.org or call (612) 928-6316 or toll free at (866) 770-7570.
Neuromuscular/General Neurologist / PM&R // Neurorehabilitation Specialist //Neurohospitalist: We are a private practice neurology group in North San Diego County consisting of seventeen physicians practicing in a number of different disciplines. We have six offices in the region and practice at Scripps Memorial Hospital Encinitas, Poway Pomerado Hospital in Escondido and Poway Valley as well as Tri City Medical Center in Oceanside. We will soon be opening a brand new office in Carlsbad, CA. This practice has been in existence since 1977 and is well positioned in the community to provide neurological services. Most partners have academic appointments at UCSD as volunteer faculty. We have a busy clinical trials practice. Our practice has grown out of a desire to combine the benefits of private practice with elements of research and academics. Our desire is to attract highly qualified, energetic and motivated BC/BE physicians as we expand our practice: Neuromuscular Specialist, Neurohospitalists, Physical Medicine and Rehabilitation specialist, General Neurologist, Neurorehabilitation specialist. Call is shared at four local hospitals. Practice has been a paperless office for over 10 years. Competitive salary and benefits package. Partnership option available. Please see our web site at www.neurocenter.com. Interested candidates should submit CV to tibbsv@neurocenter.com as well as rosies@neurocenter.com. Please visit our website: www.neurocenter.com. Please be sure to label subject line in email with CV and your name as well as position of interest. I.e. CV John Smith Neuromuscular.

General & Subspecialty Trained Neurologist: The Ochsner Neuroscience Institute is actively recruiting BC/BE Neurologist to join our expanding practice. Both newly trained and experienced physicians are encouraged to apply. We offer a highly competitive salary with comprehensive benefits. Opportunities exist at our main campus in New Orleans as well as our Baton Rouge, Kenner, North Shore, and West Bank facilities for General Neurologist and those with subspecialty training in the following areas: Cognitive Disorders, Multiple Sclerosis, Epilepsy, Neuromuscular, Headache Stroke/Vascular, Movement Disorders. Ochsner is a great opportunity to practice neurology in a collegial and patient-focused environment. Academic appointments are available at our affiliated institutions, including Tulane, LSU, and the University of Queensland. The Department of Neurology has a complement of 32 neurologists system-wide with subspecialty representation in stroke, neurocritical care, interventional neurology, neuromuscular disease, movement disorders, epilepsy, MS, headache, cognitive disorders, sleep, traumatic brain injury and sports medicine. We are a Top 25 Neuroscience Center in the latest U.S. News & World Report rankings. Ochsner Health System is southeast Louisiana’s largest non-profit, academic, multi-specialty, healthcare delivery system with 28 owned, managed and affiliated hospitals and more than 60 health centers. Ochsner employs more than 10,000 physicians in over 90 medical specialties and subspecialties, and conducts over 900 clinical research studies. For more information, please visit at www.ochsner.org. CVs will be reviewed by Richard M. Zweifler, M.D., System Chair of Neurology. Please direct any inquiries to: neurogroup@ochsner.org or call (800) 488-2240 for more information. Reference # NEUR-2. Sorry, no opportunities for J1 applicants. Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.

Neuromuscular Neurologist: Portland, Oregon: We are seeking a BC Neuromuscular Neurologist and are considering Neurologists with fellowship-level training in neuromuscular and/or neurophysiology. The chosen individual will have subspecialty, general neurology and inpatient hospital responsibilities as well as a member of an 11 Neurologist department that is pioneering integrated medical practice and is leading the way to the future of medical care. Clinical excellence and an interest in helping to pioneer new ways of providing the right neurological care at the right time for the right person will be essential to this position. Join us in the beautiful Pacific Northwest and enjoy a competitive salary in addition to an extensive benefit package which includes medical, dental, disability and life insurance, company funded/generous retirement plans; vacation, sabbatical and educational leave; and professional liability coverage. To apply, please visit our Web site at: http://nwp.kphysiciancareers.com. For more information, call Shelonda at (800) 813-3763. No J1 opportunities. We are an equal opportunity employer and value diversity within our organization.

Neurology Openings with Dignity Health in Northern California: Do you desire: Live/Work 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 AAN, 20 bed Stroke Centers, Vascular Neurologist, New Primary Care Network, 24-72 Hour 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 and 100% malpractice coverage. For more information, please contact & send your CV to: Physician Recruiting, providers@dignityhealth.org; phone: (888) 599-7787; www.dignityhealth.org/physician-careers

Neurology Department Chair: The Department of Neurology at the University of Missouri - Kansas City seeks an energetic and skilled leader to serve as Department Chair. The successful candidate will bring physician-scientist credentials demonstrated success in research, patient care, education, and administration, and will possess the personal and professional qualifications to foster clinical and academic growth of the Department. The Department Chair oversees clinical programs for Neurological Centers, a health system with two acute care hospitals, and multiple primary care practices. Clinical training facilities for medical student and resident education include Truman Medical Centers, Saint Luke’s Hospital in Kansas City, Children’s Mercy Hospitals & Clinics, and Research Medical Center. The Department Chair will foster excellence in research, maintain high standards of clinical care and patient satisfaction through

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quality improvement initiatives, and help sustain the strong undergraduate and postgraduate educational programs in the Department. The University of Missouri—Kansas City School of Medicine has more than 1500 dedicated, full-time and community-based volunteer faculty educating our medical students and residents at affiliated hospitals and clinics. The School is home to a premier accelerated, combined degree medical education program that admits students after high school and leads to BA and MD degrees in six years. Interested parties should combine all application materials (personal letter of interest with accompanying curriculum vitae and list of references) into one PDF or Microsoft Word document and upload it as an attachment in the UMKC career opportunities application at: www.umkc.edu/jobs (Professor and Chair Neurology, 57277; Job ID 19274). It is the policy of UMKC to provide equal opportunity regardless of race, creed, color, sexual orientation, national origin, age, veteran status or disability in all education, employment and contracted activities. All final candidates will be required to successfully pass a Criminal Background Check prior to beginning employment.

Director, Neuromuscular Center and EMG Laboratory
The VA Boston Healthcare System’s Neuromuscular Center and EMG Laboratory seeks a dynamic leader with management experience and a commitment to interdisciplinary and patient-centered care. B.C. in Neurology, EMG and Neuromuscular Medicine. This active program is staffed by three full-time Neurologists and has one of the largest Neuromuscular/EMG training programs in the country with 30+ residents/fellows annually. VABHS is the major tertiary referral center for Veterans throughout New England and is strongly affiliated with Harvard Medical School and Boston University School of Medicine. The program has primary affiliations with multiple residencies and fellowships, including Harvard Partners Neurology and Spaulding Physical Medicine & Rehabilitation, and Boston University Neurology. Candidate will be nominated for a faculty position at Harvard Medical School commensurate with qualifications. VABHS is an equal opportunity employer, women and minorities are strongly encouraged to apply. Email CV and cover letter to: BHSPhysicianNeurologySearch@va.gov

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 includes a comprehensive array of diagnostic imaging techniques, including 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 and stroke protocols, and direct patient care. Availability: immediate. Research interests are encouraged. Salary is $60,000.00 per year plus benefits. There is also an opportunity 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

Dates and Deadlines

MAY 2
Deadline: Annual Meeting CME
AAN.com/view/CME

MAY 9
Submission Deadline: Sports Concussion Conference Abstracts
AAN.com/view/ConcussionConference

MAY 11
Webinar: Merit, Incentives, Use, and Quality: The Alphabet Soup of Value-based Care
(Register by May 10)
AAN.com/view/pmw16

MAY 16
Application Deadline: UCNS Behavioral Neurology & Neuropsychiatry Certification and Recertification Examinations
UCNS.org/go/subspecialty/behavioral/certification

JUNE 1
Application Deadline: UCNS Fellowship Program Accreditation
UCNS.org/go/home

JUNE 14
Webinar: Get Better at Getting Better: A Neurology Guide to Quality Improvement
(Register by June 13)
AAN.com/view/pmw16

JUNE 14
Early Registration Deadline: Sports Concussion Conference
Hilton Chicago
AAN.com/view/ConcussionConference

JULY 1
Application Deadline: Transforming Leaders Program
AAN.com/view/TransformingLeaders

JULY 8–10
Sports Concussion Conference
Hilton Chicago
AAN.com/view/ConcussionConference

JULY 15
Application Deadline: UCNS Autonomic Disorders Certification Examination
UCNS.org/go/subspecialty/autonomic/certification
WHEN IT COMES TO STROKES, SECONDS COUNT. AND SO DO QUESTIONS.

With seven primary certified stroke centers across Dallas-Fort Worth, Baylor Scott & White Health is your source for stroke care. You can depend on board certified neurologists at each medical center to provide comprehensive treatment when seconds count.

Want to learn more about your risk for stroke? Take our online quiz at:

STROKEQUIZ.COM

For a physician referral or for more information about stroke care services, call 1.800.4BAYLOR or visit us online at StrokeQuiz.com.