Register Now for AAN Fall Conference
Set for October 25 to 27 in Las Vegas

The always-popular AAN Fall Conference, set for October 25 to 27, 2013, at the Encore Wynn Las Vegas, offers you a convenient way to earn up to 17.5 AMA PRA Category 1 credits before the end of the year.

The conference is ideal for those looking to enhance their clinical knowledge through the Neurology Update track, which includes a session on Continuum: Test Your Knowledge: A Multiple Choice Question Review designed to help you stay current in clinical practice. Practitioners looking to focus on coding, reimbursement, and other topics essential to running a practice will want to register for the Practice Management track. The weekend program also includes a special skills workshop on the uses of botulinum toxin, and a Saturday afternoon session to help you become a better advocate for your profession and patients in today’s turbulent health care climate.

Learn How to Make Sense of Coverage Denials

The webinar “Making Sense of Coverage Denials” will be offered live on August 13, 2013, from 12:00 p.m. to 1:30 p.m. ET. It will be presented by Joseph V. Fritz, PhD, chair-elect of BRAINS and member of the AAN Practice Committee and Payment Policy Subcommittee. The registration deadline is Monday, August 12.

Upon completion, participants should be able to:

• Proactively develop relationships with the insurers with whom they contract
• Appropriately appeal a denied claim
• Learn tips for increasing appeal success
• Document properly to avoid denials
• Properly utilize AAN resources, including the Insurer Relations Toolkit

The cost to participate in the 2013 webinars is $149 for the first and $50 for each additional webinar—more than 25 percent off the pricing for nonmembers. The bundling discount is applicable only when multiple webinars are purchased in the

Neurologist-tested, Member-approved: Experience the New AAN.com

You are encouraged to visit the newly redesigned AAN.com where all Academy resources now are centralized and easier for you to find. For the past 18 months, the AAN Website Redesign Workgroup has researched and developed a new AAN.com website that improves users’ ability to quickly find the information they need on Academy products, services, events, and advocacy initiatives. The site has been tested by members throughout the course of development, most recently at the Annual Meeting, and now is available to all.

“The new AAN.com reflects a clean and easy-to-navigate design that is the result of extensive member research and usability testing,” said Terrence L. Cascino, MD, FAAN, chair of the Academy’s Website Redesign Workgroup. “The new website is efficient and well-organized, allowing members to quickly find the resources they need at every stage of their career.”
The Vision of the AAN is to be indispensable to our members. The mission of the AAN is to promote the highest quality patient-centered neurologic care and enhance member career satisfaction.

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www.aan.com/practice/payer-relations

A hybrid open access (OA) model was implemented for Neurology® in May. Authors may now opt to pay an article processing charge of $3,000 per paper to have their work made open access within six months after publication. To fulfill the recent Research Council of the UK (RCUK) mandate for authors who receive their funding to publish OA, those authors funded by the RCUK will pay $3,100 and retain rights for commercial distribution.

The 2013 Annual Meeting had 12,135 registered attendees, up from 12,053 in 2012. Members made up 60 percent of attendees, compared to 59 percent last year. A total of 62 percent of attendees were from the United States and Canada, compared to 63 percent in 2012.

More than 600 members responded to the recent action alert asking them to sign a letter to policy makers for all offices to receive a message from our members. Please take a moment and respond to these alerts. The more messages sent, the larger the impact.
Will Our Children and Grandchildren Be Able to Find a Neurologist in 2025?
Continued from page 3

The information developed by the Workforce Task Force is being used in several ways. The AAN Board of Directors is considering ways to enhance the attractiveness of neurology and also to increase the number of family practitioners, nurse practitioners, and physician assistants trained in neurology. Because these findings demonstrate potentially significant effects on patient access to necessary and appropriate neurological care, the Academy issued a press release and presented this information to members of Congress during Neurology on the Hill meetings in April. The Academy will continue to use the impressive evidence of a growing crisis in neurological care, supplemented by additional data obtained from our recent Neurology Compensation and Productivity Survey, in our efforts to influence public policy to increase the supply of, and improve reimbursement for, neurologists and neurologic services.

If you have not yet read the first workforce study article, it can be downloaded until August 31 at http://bit.ly/13MSJSY. After that date, a Neurology subscription will be required to view it. The second article is available at http://bit.ly/13DOKja for six months. Both articles will be printed in the July 30, 2013, issue of Neurology. Another important article, “The Coming Crisis” by Dorsey et al. (Neurology 2013;80:1989-1996), further illustrates the growing burden and demand for neurologic services due to neurodegenerative diseases.

I hope you will take the time to read them, as well the report on compensation and productivity that will be available soon. It is up to each of us to be knowledgeable about these issues and also willing to discuss them with our patients, friends, community leaders, and policy makers. We must be our own best advocates. You can help by making a donation to both the American Brain Foundation and to BrainPAC when you renew your membership.

One way or another, we need to bolster our ranks while we rid ourselves of these devastating diseases. That is how we help create a better world for our children and grandchildren in 2025.

Timothy A. Pedley, MD, FAAN
President, AAN

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 www.aan.com/go/advocacy/hillreport. Below are some recent highlights.

AAN Concerns Inspire “Principal Care” Provision in SGR Fix

The Academy’s long efforts in cultivating relationships with members of Congress and using BrainPAC as a tool to help educate them on perils to neurology continue to bear fruit. Rep. Bill Cassidy, MD, (R-LA) introduced a significant revision to a Sustainable Growth Rate (SGR) formula repeal/physician payment reform bill drafted by the House Energy & Commerce Committee, of which Cassidy is a member. The revision includes a “Principal Care Physician Practice (PCPP) Alternative Medicare Payment Model” that Cassidy said is a result of long standing AAN concerns.

Practice Innovators Network

AAN Past President Bruce Sigsbee, MD, FAAN, has joined the AAN advocacy team as a health policy consultant. He will launch the “Practice Innovators Network” in September. This virtual roundtable will bring together AAN members who are embracing new technology and models of care and employing them in their practices, as well as members who need to get up to speed or seek guidance as they tackle these changes. Contact Elizabeth Bradshaw at ebradshaw@aan.com to participate in the first roundtable webinar.

AUBAGIO (teriflunomide) 14 mg tablet

IN THE TREATMENT OF RELAPSING FORMS OF MS

DON’T LET MS
DEFINE YOUR PATIENTS

WARNING: HEPATOTOXICITY AND RISK OF TERATOCGENICITY

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. If drug induced liver injury is suspected, discontinue AUBAGIO and start an accelerated elimination procedure with cholestyramine or charcoal. AUBAGIO is contraindicated in patients with severe hepatic impairment. 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 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 on the following pages.
**INDICATION**
AUBAGIO® (teriflunomide) is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

**IMPORTANT SAFETY INFORMATION**

**Hepatotoxicity**—AUBAGIO is contraindicated in patients with severe hepatic impairment and in patients taking leflunomide. Severe liver injury, including fatal liver failure, has been reported in patients treated with leflunomide, which is indicated for rheumatoid arthritis. Teriflunomide is the principal active metabolite of leflunomide. A similar risk would be expected for teriflunomide because recommended doses of teriflunomide and leflunomide provide similar plasma concentrations of teriflunomide. Obtain transaminase and bilirubin levels within 6 months before starting AUBAGIO; monitor ALT levels at least monthly for 6 months after starting AUBAGIO. Patients with preexisting liver disease may be at increased risk of elevated serum transaminases when taking AUBAGIO. Patients with preexisting acute or chronic liver disease, or those with serum alanine aminotransferase (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, AUBAGIO was discontinued and patients underwent accelerated elimination.

Consider additional monitoring if coadministering AUBAGIO with other potentially hepatotoxic drugs because of increased risk of severe liver injury; monitor patients who develop symptoms suggestive of hepatic dysfunction (e.g., unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine). If drug-induced liver injury is suspected, discontinue use of AUBAGIO, start accelerated elimination, and monitor liver tests weekly until normalized.

**Risk of Teratogenicity**—AUBAGIO is contraindicated in pregnant women or women of childbearing potential who are not using reliable contraception. Based on animal data, AUBAGIO may cause major birth defects if used during pregnancy. Before starting therapy, pregnancy must be excluded, use of reliable contraception confirmed, and the patient fully counseled. Patients have delayed onset of menses or other reason to suspect pregnancy should immediately notify their physician and be apprised of the potential hazards to the fetus. If the patient is pregnant or wishes to become pregnant, treatment should be discontinued immediately, followed by accelerated elimination until plasma concentrations of <0.02 mcg/mL are verified. It is not known whether AUBAGIO passes into breast milk; patients should be counseled on whether they should take AUBAGIO or breastfeed—they should not do both at the same time. Women who become pregnant while taking AUBAGIO should enroll in the AUBAGIO Pregnancy Registry to monitor fetal outcomes, by calling 1-800-745-4447, option 2.

AUBAGIO is eliminated slowly from the plasma. Without accelerated elimination, reaching plasma concentrations of <0.02 mcg/mL takes an average of 8 months or, in some patients, up to 2 years. Accelerated elimination may cause disease activity to return in patients who were responding to AUBAGIO treatment. AUBAGIO is detected in human semen. Men not wishing to father a child should use reliable contraception to minimize possible risk. Men wishing to father a child should discontinue AUBAGIO and undergo accelerated elimination until plasma concentrations of <0.02 mcg/mL are verified.

**Additional Safety Information**
Decreases in white blood cell counts, mainly of neutrophils and lymphocytes, and platelets have been reported in clinical studies of AUBAGIO. Obtain a complete blood cell count within 6 months before starting treatment. Further monitoring should be based on symptoms suggestive of bone marrow suppression. AUBAGIO is not recommended for patients with severe immunodeficiency, bone marrow disease, or severe uncontrolled infections. Treatment in patients with infection(s), acute or chronic, should not be started until the infection(s) is resolved. Medications such as teriflunomide have immunosuppressive potential; patients may therefore be more susceptible to infections. The risk of malignancy, particularly lymphoproliferative disorders, is increased with some immunosuppressive medications.

Vaccination with live vaccines is not recommended. Tuberculosis has been observed in clinical studies of AUBAGIO. Before starting treatment, screen patients for latent tuberculosis infection with a tuberculin skin test.

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.

Transient acute renal failure and treatment-emergent hyperkalemia, as well as increased renal uric acid clearance, has been reported with AUBAGIO. Monitor renal function and potassium if symptoms of acute renal failure or hyperkalemia appear.

Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported rarely in rheumatoid arthritis patients receiving leflunomide, with a similar risk expected for teriflunomide; therefore, stop treatment and use accelerated elimination if a severe skin reaction develops.

Increased blood pressure has occurred with AUBAGIO. Hypertension was reported in 4% of patients taking AUBAGIO vs 2% on placebo. Measure blood pressure at treatment initiation and manage appropriately during treatment.

Intestinal lung disease and worsened preexisting intestinal lung disease have been reported with leflunomide, with a similar risk expected with teriflunomide.

Teriflunomide is an inhibitor of CYP2C8 and may be a weak inducer of CYP1A2. Monitor patients when teriflunomide is coadministered with drugs metabolized by these pathways.

A 25% decrease in peak international normalized ratio (INR) was observed when teriflunomide was coadministered with warfarin vs warfarin alone. Close INR follow-up and monitoring are recommended.

The type or dose of oral contraceptives used in combination with teriflunomide should be considered because of increased ethinylestradiol and levonorgestrel levels following repeated doses of teriflunomide.

The most frequent adverse reactions (≥10% and <2% greater than placebo) with AUBAGIO 7 mg and 14 mg and placebo, respectively, were ALT increased (12% and 14% vs 7%), alopecia (10% and 13% vs 3%), diarrhea (15% and 18% vs 9%), influenza (9% and 12% vs 10%), nausea (9% and 14% vs 7%), and pyrexia (9% and 10% vs 8%).

The safety and effectiveness of AUBAGIO have not been established in pediatric patients and in patients aged >65 years.
**INDICATIONS AND USAGE**

AUBAGIO is indicated for the treatment of patients with relapsing forms of multiple sclerosis (see Clinical Studies (14) in the full prescribing information).

**DOSE AND ADMINISTRATION**

The recommended dose of AUBAGIO is 7 mg orally once daily, AUBAGIO can be taken with or without food.

**Overall discontinuation rate due to AEs was 10.9% with AUBAGIO 14 mg, 9.8% with AUBAGIO 7 mg, and 8.1% with placebo.**

**ONCE-Daily oral dosing**

- Once-daily tablet can be taken at any time, with or without food.

**SAFETY PROFILE informed by >1300 patient-years of exposure in Phase II and TEMSO Phase III trials**

- The most frequent adverse reactions (incidence ≥10% and ≥2% greater than placebo) with AUBAGIO 14 mg, AUBAGIO 7 mg, and placebo, were: alopecia, maculopapular rash, pyrexia, upper respiratory tract infection, arthralgia, nausea, constipation, tachycardia, edema, weight gain, and fever.

**INDICATIONS AND USAGE**

AUBAGIO is indicated for the treatment of patients with relapsing forms of multiple sclerosis (see Clinical Studies (14) in the full prescribing information).

**DOSE AND ADMINISTRATION**

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

**Monitory to assess safety**

- Obtain transaminase and bilirubin levels within 6 months before initiation of AUBAGIO therapy. Monthly ALT levels at least 6 months after starting AUBAGIO (see Warnings and Precautions (5.1))
- Obtain a complete blood cell count (CBC) within 6 months before the initiation of AUBAGIO. Further monitoring should be based on signs and symptoms of infection (see Warnings and Precautions (5.4)).
- Prior to initiating AUBAGIO, assess for latent tuberculosis infection with a tuberculin skin test (see Warnings and Precautions (5.4)).
- Check blood pressure before the initiation of AUBAGIO treatment and periodically thereafter (see Warnings and Precautions (5.8)).

**CONTRAINDICATIONS**

4. Severe Hepatic Impairment

- Patients with severe hepatic impairment (see Warnings and Precautions (5.3)).

4.2 Patients Who are Pregnant or Women of Childbearing Potential Not Using Reliable Contraception

- Women who are pregnant or who are not using reliable contraception should not be given AUBAGIO. AUBAGIO is contraindicated in patients with severe hepatic impairment (see Contraindications (4.3)).

**WARNING REGARDING HEPATOTOXICITY AND USE IN PREGNANCY**


**AUBAGIO® (teriflunomide) tablets for oral administration**

**Brief Summary of Prescribing Information**

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AUBAGIO® is available in 14 mg and 7 mg tablets.

**WARNINGS: HEPATOTOXICITY AND RISK OF TERATOGENICITY**

**Hepatotoxicity**

Severe liver injury including total liver failure has been reported in patients treated with leflunomide, which is related to hepatotoxicity. A similar risk would be expected for AUBAGIO because of its close resemblance to leflunomide. Patients with pre-existing liver disease may be at higher risk of developing severe liver transaminase increases when taking AUBAGIO. Patients with pre-existing acute or chronic liver disease, or those with serum alanine aminotransferase (ALT) increases 3 times the upper limit of normal (ULN) before initiating AUBAGIO treatment, should not normally be treated with AUBAGIO. AUBAGIO is contraindicated in patients with severe hepatic impairment (see Contraindications (4.3)).

In placebo-controlled trials, ALT plateaued from times three the ULN in one patient and 2 of the 2 patients with ALT >5 times the ULN in two other patients. In those studies, most patients had returned to normal or near normal values within 2 months.

One patient in the controlled trials developed ALT levels ≥10 times the ULN and jaundice 5 months after initiation of AUBAGIO 14 mg treatment. The patient was hospitalized for 5 weeks and recovered after plasma exchange and hematopoietic support. Teriflunomide-induced liver injury in this patient could not be ruled out.

Obtain serum transaminase (ALT) levels at least monthly for six months after starting AUBAGIO therapy. Monitor ALT levels at least monthly for six months after starting AUBAGIO. Consider discontinuing AUBAGIO if serum transaminase increases greater than three times the ULN is continued. Monitor serum transaminase (ALT) levels in patients who develop symptoms suggestive of hepatic dysfunction, such as unexplained weight loss or fatigue. If jaundice occurs or if jaundice is suspected, discontinue AUBAGIO and will be considered.

5.1 Hepatitis

- Teriflunomide is contraindicated in patients who develop liver injury.

- Severe liver injury including total liver failure has been reported in patients treated with teriflunomide, which is related to hepatotoxicity. A similar risk would be expected for AUBAGIO because of its close resemblance to leflunomide.

- Patients with pre-existing liver disease may be at higher risk of developing severe liver transaminase increases when taking AUBAGIO. Patients with pre-existing acute or chronic liver disease, or those with serum alanine aminotransferase (ALT) increases 3 times the upper limit of normal (ULN) before initiating AUBAGIO treatment, should not normally be treated with AUBAGIO. AUBAGIO is contraindicated in patients with severe hepatic impairment (see Contraindications (4.3)).

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risk for peripheral neuropathy leflunomide. There have also been reports of peripheral neuropathy in patients receiving AUBAGIO, respectively, compared with 0% on placebo. Treatment was discontinued in 2 patients with multiple sclerosis, the incidence of peripheral neuropathy confirmed by nerve conduction studies in 1 patient who received 7 mg teriflunomide and 1 patient who received 14 mg of teriflunomide, respectively, compared with 0% on placebo. Treatment was discontinued in 3 patients with peripheral neuropathy confirmed by nerve conduction studies in the placebo group. There was no reported treatment-related increase in creatinine in any of the groups. No adverse events in controlled clinical studies as compared to placebo (0.5% and 1.4% of patients for teriflunomide 7 mg and 14 mg, respectively, and 0% on placebo).

5.6 Acute Renal Failure

In placebo-controlled trials, 10 of 984 (1.2%) of AUBAGIO treated subjects had transient acute renal failure with a creatinine measurement increased by 100% or more above baseline, compared with 0% of patients on placebo. In 16 of the 10 patients, the acute renal failure resolved with discontinuation of AUBAGIO therapy and discontinuing AUBAGIO therapy and performing an accelerated elimination procedure [see Warnings and Precautions (5.10)]. No inciting factors, such as dehydration, exercise, or increase in creatinine, were reported, this information was not systematically collected. No clinical data are available on the efficacy and safety of vaccinations in patients taking AUBAGIO. There was an increase in mean repaglinide Cmax and AUC 0–24 (1.58- and 1.54-fold, respectively) in subjects who received concurrent treatment with teriflunomide and repaglinide as compared to repaglinide alone. These increases may contribute to the risk for hypoglycemia when teriflunomide is coadministered with repaglinide.

8.6 Hepatic Impairment

Safety and effectiveness in pediatric patients have not been established. The pharmacokinetics of teriflunomide in severe hepatic impairment have not been evaluated. No dosage adjustment is necessary for patients with mild and moderate hepatic impairment. The pharmacokinetics of teriflunomide in severe hepatic impairment have been evaluated. Teriflunomide is contraindicated in patients with severe hepatic impairment (see Contraindications (4.2) and Warnings and Precautions (5.2)).

10. OVERDOSAGE

Exposure to teriflunomide are normal in plasma, with minimal maternal toxicity. Maternal plasma exposure at the no-effect dose (1.0 mg/kg/day) was not systematically collected. No data are available on the incidence of fetal malformations at doses associated with maternal toxicity. Although teriflunomide did not cause fetal toxicity at doses associated with maternal toxicity, there is a potential for teratogenic effects with in utero exposure, especially to the offspring of mothers that were exposed to teriflunomide in late pregnancy. If teriflunomide is needed in pregnancy, consideration should be given to discontinuing the drug during the first trimester. No data are available from controlled studies in pregnant women to assess fetal risk. In the teratogenicity studies in rats, teriflunomide was administered to rats during gestation and lactation, decreased growth, eye and skin abnormalities, and embryofetal death at doses associated with maternal toxicity. Maternal plasma exposure at the no-effect dose (1.0 mg/kg/day) was not less than that in humans at the maximum recommended human dose (MRHD, 14 mg/day). Teriflunomide was administered to rats in late pregnancy, and fetal administration of teriflunomide (40 mg/kg). Maternal plasma exposure at the no-effect dose (1.0 mg/kg/day) was not less than that in humans at the maximum recommended human dose (MRHD, 14 mg/day).

Table 1 Table 1 Adverse Reactions in Study 1 (occurring in ≥ 2% of patients, and reported for teriflunomide 7 mg or 14 mg or ≥ 2% higher than on placebo).

<table>
<thead>
<tr>
<th>PRIMARY SYMPTOM OR CLASS</th>
<th>Teriflunomide 7 mg (N=368)</th>
<th>Placebo (N=360)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Abdominal distension</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Pruritus</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Nasal congestion</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Sciatica</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Meningitis</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Abnormal vision</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Vascular disorders</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Practices Find PQRS Reporting Fairly Straightforward

The Physician Quality Reporting System (PQRS) was established by the Centers for Medicare & Medicaid Services to provide an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional sed services furnished to Medicare beneficiaries. Two AAN members who administer their clinics’ reporting shared their experiences taking different approaches to the process of recording and reporting data.

Joseph V. Fritz, PhD, is chief executive officer at the Dent Neurologic Institute in Amherst, NY; a member of the AAN Practice Committee and Payment Policy Subcommittee; and chair-elect for BRAINS. He said his organization was a bit late to this process but, as part of an accountable care organization (ACO), it was able to submit their data as a group in 2013 for work done in 2012.

How did you submit data and on which measures?

“The ACO provided to us a list of candidate PQRS metrics. The provider just clicks on which ones were done: e.g., counseling on smoking, e-prescribing, BMI. To actually provide the educational tools, our MAs hand out the card described above. We also have a link to A.D.A.M. Education [an online resource that provides patient educational materials] on our website, and can send EHR-based documentation to the portal. In all, this has become an easy process. Staff and automation absorb the majority of the effort so as to minimize impact on provider flow.”

How will you use your financial incentive for participating?

“We have not received any payments yet. We initiated PQRS at the last minute to avoid the penalties. Once we found out how easy the process can be, we were kicking ourselves for not starting earlier.”

What advice do you have for others?

“Keep the metrics as simple as possible. If already attesting for Meaningful Use, there is likely overlap in data you are collecting and processes the providers are doing. We took the strategy that it is best to get going with the mechanics of something easy, rather than treat this as a true neurology quality indicator. We know this will come with time. But if you don’t take baby steps, the documentation burden can be enormous and negatively impact quality by making physicians inattentive to their patients.”

Update on the Neurology Group

William S. Henderson, FACMPE, administrator of The Neurology Group, LLP, in Albany, NY, and a member of the AAN Medical Economics and Management Committee, spoke about his practice’s adoption of quality reporting in the July 2012 issue of AANews. He recently said that the process continued through 2012 with few glitches.

“We were an EHR submitter, which requires that the process goes through the QualityNet website established by CMS and follows CMS security measures. You have to think about this because you need to assign a security officer for the practice who doesn’t have any direct involvement in reporting but who assigns people rights for what they can report for the practice. So, our security officer assigned me rights to submit data.

“Once you get over that hump, you’re pretty well set. We’d been collecting data all year in 2012 through our EHR. Using the available software, we did test runs and then uploaded data to the QualityNet website.

“The process is pretty painless as long as everything is working fine on the QualityNet site. Sometimes we submitted data that was rejected because of a hiccup in their system, but those are things you run into from time to time and you just need to resubmit.

“We won’t receive verification of our incentive award until later in 2013, and we’ll just put that toward the overall revenue in the practice. My advice to groups our size (eight doctors and three non-physicians) is to make sure your EHR will allow you to submit directly to CMS.”
Register Now for AAN Fall Conference Set for October 25 to 27 in Las Vegas

Continued from cover

“The Fall Conference offers a unique opportunity to get updated on current neurologic topics and practice issues,” said J. Clay Goodman, MD, FAAN, who co-directs the Neurology Update Program with Joseph E. Safdieh, MD. “Our faculty—all experts in their fields—will be emphasizing updates in the diagnosis, management, and the most current treatment modalities using lectures and clinical case discussions.”

Save an additional 10 percent when you register for a full Neurology Update or Practice Management track! Register by October 1 to take advantage of this bonus discount—visit www.aan.com/go/education/conferences/fall2013.

Friday, October 25
8:00 a.m.–5:00 p.m.  |  Dystonia Skills Workshop
Director: Barbara P. Karp, MD
8:00 a.m.–12:00 p.m.  |  Neuromuscular Disease Update
Director: P. James B. Dyck, MD, FAAN
Practice Management 101: Coding and Documentation
Today—A Case-based Approach
Director: Marc R. Naver, MD, PhD, FAAN
1:00 p.m.–5:00 p.m.  |  Neurology Update I
Directors: Joseph E. Safdieh, MD, and J. Clay Goodman, MD, FAAN
Topics include:
- Neuroinfectious Disease
- Neurology and Pregnancy
- Epilepsy
Practice Management 201: How to Succeed in an Environment in Transition
Director: Orly Avitzur, MD, MBA, FAAN
Saturday, October 26
8:00 a.m.–12:00 p.m.  |  Neurology Update II
Directors: Joseph E. Safdieh, MD, and J. Clay Goodman, MD, FAAN

Leadership
Leadership is organizing a group of people to achieve a common goal. A leader may or may not have authority. Leaders are produced through a variety of means.

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J. Clay Goodman, MD, FAAN
October 25–27, 2013
Encore at Wynn Las Vegas

Topics include:
- Dementia
- Movement Disorders
- Stroke

Practice Management 301: The Future Practice of Neurology: From Quality to Data and the Impact of Payment Reform
Director: David A. Evans, MBA
1:00 p.m.–5:00 p.m.
Continuum® Test Your Knowledge: A Multiple Choice Question Review
Director: Ralph F. Józefowicz, MD, FAAN
Physician-led Advocacy: Are You an Effective Advocate for Neurology?
Director: Nicholas Elwood Johnson, MD
5:15 p.m.–6:15 p.m.  |  FREE Maintenance of Certification Informational Session
Presenters: Ralph F. Józefowicz, MD, FAAN, Neurology Director, ABPN; and Cynthia L. Comella, MD, FAAN, Chair, AAN Education Committee
Sunday, October 27
7:30 a.m.–11:30 a.m.  |  Neurology Update III
Directors: Joseph E. Safdieh, MD, and J. Clay Goodman, MD, FAAN
Topics include:
- Multiple Sclerosis
- Neuro-ophthalmology
- Headache

Program schedule is tentative and subject to change.
ABPN-approved Program for Maintenance of Certification

“The June/July Neurology Now® features media personality Jack Osbourne, son of Ozzy and Sharon Osbourne, who was diagnosed with MS at age 26. Osbourne, a new father, shares why he went public with his diagnosis and discusses how MS impacts someone on the threshold of major life decisions.

Other stories look at headaches in children, brain imaging, how to build a financial and legal safety net while living with a neurologic condition, and controlling blood pressure to protect the brain from dementia, which appears in a new department called The Healthy Brain. Visit NeurologyNow.org for more information about the AAN’s free bi-monthly magazine for neurology patients, their families, and caregivers. AAN members may receive up to 30 free copies of each issue to distribute to patients. To adjust the number of copies of Neurology Now received in your office, contact AAN Member Services at (800) 879-1960, or update your member profile at www.aan.com/view/profile.

“Physician-led Advocacy: Are You an Effective Advocate for Neurology?”
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Get Ready for Neurology Career Week, October 7 to 11

Mark your calendar for the AAN’s popular Neurology Career Week, an event for all members who are looking for a new position or are hiring new staff.

Is a New Job in Your Future?
Now is a good time to prepare for Neurology Career Week. Take part in the Online Job Fair, webinars, free CV reviews, and personal coaching sessions. Create or update your Career Center Job Seeker profile between August 1 and October 11 for a chance to win a $500 Visa gift card and other prizes. To learn more, visit www.aan.com/careers/career-events.

Are You Seeking New Staff?
A free webinar, “Neurology Recruitment Advertising for 2013 Career Week,” will be offered on Thursday, July 25, at 5:00 p.m. CT. Learn about advertising options and deadlines for Career Week. Choices include the Online Job Fair, Careers E-newsletter, and print advertising in Career Compass. The newsletter and Career Compass have limited space and are expected to sell out. To learn more about these high-readership opportunities, register for the free webinar at aan.com/view/recruit. For assistance with your advertising, contact careers@aan.com to schedule an appointment.

Neurologist-tested, Member-approved: Experience the New AAN.com

Continued from cover

Supported by a new simpler, intuitive design:
• You can access your AAN publications more quickly
• Your CME and Maintenance of Certification resources are integrated
• Additional resources can help you strengthen your practice
• The robust search engine is more responsive

New Area Devoted to Residents and Fellows

The reworking of the site also has produced a new Residents & Fellows area, which brings together the tools and resources young neurologists need at this stage of their careers.

Visit the new AAN.com website and take advantage of its dynamic, timely delivery of the critical information neurologists need for success.

Up Next: New Mobile Site

The Website Redesign Workgroup now will begin researching and developing a newly redesigned m.AAN.com. More details will be announced soon.

For more information, please visit Tecfidera.com
Multiple Sclerosis Is Focus of Latest Continuum Audio

A discussion involving the diagnosis, management, and treatment of multiple sclerosis is the focus of the July and August issues of Continuum® Audio, the AAN’s exclusive CME audio program.

“The Continuum Audio series on MS provides the most up-to-date and practical information regarding the diagnosis and management of patients with MS and related illnesses,” said Associate Editor Steven L. Lewis, MD, FAAN. “All neurologists will benefit from hearing the experts discuss the newest diagnostic criteria, the expanding treatment options, and other important contemporary issues related to the care of our patients with demyelinating diseases.”

The four-part series includes:

**Hour 1:**
- Diagnosis and Differential Diagnosis of Multiple Sclerosis
  - Fred D. Lublin, MD, FAAN

**Hour 2:**
- Current and New Directions in MRI in Multiple Sclerosis
  - Eric Klawiter, MD

**Hour 3:**
- Pathology of Multiple Sclerosis: Where Do We Stand?
  - Claudia Lucchinetti, MD, FAAN

**Hour 4:**
- Present and Emerging Therapies for Multiple Sclerosis
  - Andrew J. Solomon, MD
- Diagnosis and Differential Diagnosis of Multiple Sclerosis
  - Laura Balcer, MD, MSCE, FAAN
- Present and Emerging Therapies for Multiple Sclerosis
  - Claudia Lucchinetti, MD, FAAN
- Anticoagulants for Prevention of Strokes in Multiple Sclerosis
  - Melissa Armstrong, MD

Continuum Audio includes probing discussions with authors of selected articles published in the official CME journal of the AAN, Continuum: Lifelong Learning in Neurology®. These conversations focus on case studies and emphasize important decisions clinicians face in their day-to-day practices. The topics covered in Continuum Audio mirror the current print issue with new one-hour programs available biweekly. With 24 hours of audio programming per year, participants may earn up to 2 AMA PRA Category Credits per program (or up to 48 per year).

Each month, Continuum Audio subscribers receive two audio CD programs accompanied by a detailed written summary with educational objectives and test questions. Continuum Audio provides the convenience of listening to programs almost anywhere.

You also can access your content and CME testing on the Audio-Digest website at audiodigest.org or listen to each program through the Continuum Audio app, now available for download for your iPad®, iPhone, or Android® device. Download the app for free.

Subscriptions for AAN members are $399 per year, a $100 savings from the nonmember rate. Continuum Audio is free for junior members, who may register for access at www.audiodigest.org/janmemember. Single issues, including CME, are $25 per issue. Visit www.aan.com/go/eLibrary/continuumaudio to learn more and subscribe.

Periprocedural Risks of Antithrombotic Medications Examined in New Guideline

A new guideline from the AAN recommends that people who take antithrombotic medications for stroke should work closely with their physicians or medical care teams to determine whether these medications should be continued to maintain stroke prevention efforts or temporarily stopped to lower the risk of bleeding with the procedure. “Evidence-based Guidelines: Periprocedural Management of Antithrombotic Medications in Patients with Ischemic Cerebrovascular Disease” was published in Neurology® on May 28, 2013.

“There may be millions of Americans taking antithrombotic medications for stroke prevention. For every dental procedure, minor medical procedure, or surgery these people plan to have, it is important to balance stroke risk from stopping an antithrombotic agent with a procedure’s bleeding risk if the medication is continued,” said lead author Melissa Armstrong, MD. “This guideline helps patients and doctors know what evidence tells us about these different risks. A person’s health history and preferred course of action are also important to discuss when making this decision,” Armstrong added.

The available evidence varies from medication to medication and patients, a slide presentation, and a clinical example are available on Neurology®. For more information, contact Julie Cox at jcox@aan.com or (612) 928-6069.

UCNS Accreditation Annual Fee to Increase

The United Council for Neurologic Subspecialties’ (UCNS) annual fee for accredited programs will increase in 2014. The fee will rise from $1,150 to $1,500. This is the first increase in accreditation fees and is designed to cover administrative costs associated with the rising number of UCNS programs.

Accredited programs pay the fee by July 1 each year. The new program application fee, which includes the first year’s annual fee, will also increase, from $3,150 to $3,500 effective June 1, 2014. The continuing accreditation fee of $1,000 will not increase.

For more information, contact Amanda Carpenter at acarpenter@ucns.org or (612) 928-6399.
**INDICATION**
Oxtellar XR™ (oxcarbazepine) extended-release tablets for oral use

**CONTRAINDICATIONS**
- Oxtellar XR is contraindicated in patients with a known hypersensitivity to oxcarbazepine or to any of its components.
- Oxtellar XR, the drug should be discontinued and an alternative treatment considered if a patient develops any of these reactions after treatment with Oxtellar XR. (Please see WARNINGS section of complete prescribing information.)

**WARNINGS & PRECAUTIONS**
- Clinically significant hypoaesthesia (sodium <125 mmol/L) may develop during treatment. Measurement and laboratory tests of serum sodium concentrations should be considered for patients during maintenance treatment with Oxtellar XR, particularly if the patient is receiving other medications known to decrease serum sodium levels. Discontinuation of oxcarbazepine treatment may be clinically required.
- Rare cases of anaphylaxis and angioedema involving the larynx, glottis, lips, and eyelids have been reported in patients after taking the first or subsequent doses of oxcarbazepine. Angioedema associated with laryngeal edema can be fatal. If a patient develops any of these reactions after treatment with Oxtellar XR, the drug should be discontinued and an alternative treatment started. Do not rechallenge these patients with Oxtellar XR.
- Inform patients who have had hypersensitivity reactions to carbamazepine that approximately 25% to 30% of them will experience hypersensitivity reactions with Oxtellar XR. Patients with a history of hypersensitivity reactions to carbamazepine should ordinarily be treated with Oxtellar XR only if the potential benefit justifies the potential risk. Discontinue Oxtellar XR immediately if signs or symptoms of hypersensitivity develop.
- Serious dermatological reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis, have been reported in association with oxcarbazepine use. Should a patient develop a skin reaction while using Oxtellar XR, consideration should be given to discontinuing its use. (Please see WARNINGS section of complete prescribing information.)
- Anyone considering prescribing Oxtellar XR must balance the risk of suicidal thoughts and behavior and should be aware of the potential for increased seizure frequency.
- Multi-organ hypersensitivity reactions have occurred in patients being treated with oxcarbazepine therapy. While there have been a limited number of reports, many of these cases resulted in hospitalization and some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement (nosocomial pneumonia, hepatitis, interstitial nephritis, and toxic epidermal necrolysis). Some were life-threatening. (Please see WARNINGS section of complete prescribing information.)
- Clinical and preclinical studies did not demonstrate increased potential for increased seizure frequency. However, like all antiepileptic drugs, Oxtellar XR may cause potential for increased seizure frequency. If this reaction is suspected, discontinue Oxtellar XR and initiate alternative treatment.
- Rare reports of hematological events such as pancytopenia, agranulocytosis, and leukopenia have been seen in patients treated with oxcarbazepine and discontinuation of therapy should be considered if any evidence of these hematological events develop.
- Due to physiological changes during pregnancy, plasma concentrations of the active metabolite of oxcarbazepine, the 10-monohydroxy derivative, may gradually decrease throughout pregnancy. Monitor patients carefully during pregnancy and through the postpartum period because the active metabolite concentrations or levels may increase after delivery. It is recommended that patients taking Oxtellar XR be enrolled in the NAAED Pregnancy Registry.

**DOSEING CONSIDERATIONS**
- Enzyme inducing antiepileptic drugs such as carbamazepine, phenobarbital, and phenytoin decrease the exposure to MHD, the active metabolite of Oxtellar XR. Dosage increases may be necessary.
- In patients with severe renal impairment, initiate Oxtellar XR at a lower starting dose and increase, if necessary, at a slower than usual rate until the desired clinical response is achieved.
- Concurrent use of Oxtellar XR with hormonal contraceptives and other oral or implant contraceptives may decrease plasma levels and render these contraceptives less effective. Additional non-hormonal forms of contraception are recommended.

**ADVERSE REACTIONS**
The most commonly observed (≥ 1%) adverse reactions seen in association with Oxtellar XR and more frequent than in placebo-treated patients were (1200 mg, 2400 mg, v placebo): dizziness (20%, 41%, v 15%), somnolence (12%, 14%, v 9%), headache (8%, 15%, v 5%), balance disorder (6%, 7%, v 5%), tremor (6%, 1%, v 2%), vomiting (6%, 15%, v 9%), diplopia (10%, 14%, v 4%), asthma (3%, 7%, v 1%), and fatigue (8%, 3%, v 1%).

Please refer to the full Prescribing Information for Oxtellar XR. Please see the brief summary for Oxtellar XR on the adjacent pages.

**For more information, please visit www.OxtellarXR.com**
**INDICATIONS AND USAGE**

OXTELLAR XR (oxcarbazepine) extended-release tablets, for oral use

**WARNINGS AND PRECAUTIONS**

**CONTRAINDICATIONS**

**CONCOMITANT ANTIEPILEPTIC DRUGS -**

When increasing the dosage of Oxtellar XR ™ , it is recommended to do so in increments of 300 mg to 450 mg per day to achieve the desired clinical response.

**Dosage**

**Hypersensitivity to Carbamazepine -**

**SUIUCIDAL BEHAVIOR AND IDEATION -**

**ADVERSE REACTIONS -**

**INDICATIONS AND USAGE**

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**ADVERSE REACTIONS -**
Posner Receives A.B. Baker Award for Lifetime Achievement in Neurologic Education

Jerome B. Posner, MD, FAAN, has been awarded the 2014 A.B. Baker Award for Lifetime Achievement in Neurologic Education. Posner, who is professor of neurology and neuroscience at Cornell University Medical College and former chairman of neurology at Memorial Sloan-Kettering Cancer Center, has been a national leader in neurologic education.

“Dr. Jerome Posner has been a superior educator of medical students, neurology residents, and fellows for over 50 years,” Robert L. Ruff, MD, PhD, FAAN, of Case Western Reserve University in Cleveland, wrote in nominating Posner. “He is a superb lecturer and by consensus of the recent gathering of trainees of the New York Hospital/Memorial Sloan Kettering/Cornell Neurology Training Program the best educator in clinical neurology and the best bedside teacher of the neurological examination and history. In 2012, I established the Neurology Teaching Award of the Neurology Services of the Department of Veterans Affairs of the United States. This award recognizes the individual whom the VA Service Chiefs (the Neurology Service Directors at each VA Medical Center) chose as their best educator/mentor. Jerry Posner was the clear winner of the first award.”

“I am truly honored to be included in the company of such distinguished previous recipients of this award,” said Posner. “It shows how much the AAN values education and educators. After more than 50 years of being able to do what I love—share my passion for neurology with eager, budding young neurologists—I am most grateful to be recognized in this special way.”

Posner’s most notable national accomplishments in the area of neurologic education include co-authoring the well-known book Plum and Posner’s Diagnosis of Stupor and Coma and establishing neuro- oncology as a clinical subspecialty. Posner is also a member of the Institute of Medicine, the Harvey Foundation, and the New York Academy of Science.

An AAN member since 1958, Posner served on the AAN Board of Directors from 1975 to 1977, has served on numerous AAN committees and subcommittees, gave the Robert Wartenberg lecture in 1989, was also selected by his peers as an opinion leader for the AAN Quesntessentials module on dementia, and is a current member of the Neuro- oncology Section and Senior Member Consortium.

In adding his support for Posner receiving this award, A.B. Baker Section of Neurologic Educators Chair Barney Stern, MD, FAAN, said “Dr. Posner is one of the most distinguished neurologic educators with local, national, and international stature. He has published over 400 peer-reviewed articles and has received numerous honorary awards. His monograph, co-authored with Dr. Fred Plum, on The Diagnosis of Stupor and Coma has been ‘must reading’ for generations of neurologists. He has received universal recognition for his pioneering work in neuro-oncology and paraneoplastic disorders. He has exhibited decades of leadership, creativity, and scholarship in the field of neurologic education.”

The award will be presented to Posner at the 2014 AAN Annual Meeting in Philadelphia. Nominations for the 2015 A.B. Baker Award for Lifetime Achievement in Neurologic Education will be accepted beginning fall 2013 at www.aan.com/go/about/sections/ablaker. For more information, contact Nancy Poechmann at npoechmann@aan.com or (612) 928-6103.
Eyes Provide a Window to Frontotemporal Dementia

Frontotemporal dementia (FTD) is one of the most common causes of dementia in people under 60, and no treatments are available for this disease that robs people of their personality.

With a 2013 Clinical Research Training Fellowship from the American Brain Foundation, the foundation of the American Academy of Neurology, Michael E. Ward, MD, PhD, hopes to better understand this disorder and eventually develop therapies for it.

“The causes of neuron death in dementing illnesses are still poorly understood, partially because little to no neuron loss occurs in the brains of many mouse models of these human diseases,” said Ward, a fellow at Gladstone Institutes at UCSF. “We have discovered that the retina is an especially vulnerable portion of the CNS in FTD. Using the retina to model this disease, we have discovered that there are abnormalities in how proteins move in and out of the nuclei of neurons in this disease that are linked to neuron death. We are studying why these abnormalities occur, and if reversal of these abnormalities can prevent disease.”

Ward is working with mentors Li Gan, PhD, and Ari Green, MD, MCR, who was himself a recipient of an American Brain Foundation Clinical Research Training Fellowship in 2005 and has served as a mentor to two previous recipients.

Ward’s research has expanded the focus of Green’s lab, which had been using the retina as a model to investigate the neurodegenerative aspect to multiple sclerosis.

“Michael’s background and training in microscopy and his skills in biochemistry and neurobiology make him uniquely positioned to explore the retina as a model for understanding neurodegenerative disease,” said Green. “His work promises to reveal important insights about FTD as well as give us insights into neurodegeneration in general.”

Funding from the American Brain Foundation meets a critical need for young researchers who are no longer able to obtain federal funding that was available several years ago, Ward said. “The American Brain Foundation is providing bridge funding to allow us to do bold research early in our careers,” he said. “If that funding was not available, a lot of people would decide that research was not for them and turn to other endeavors simply for financial reasons. We would have many fewer potential bright minds entering basic research and translational research to try to cure neurodegenerative disease and other neurologic diseases.”

An unexpected benefit of the American Brain Foundation fellowship has been the development of a community of fellow recipients, Ward said. “Just at the AAN Annual Meeting this year I’ve met all of these colleagues doing tremendous work, and we’ve already struck up collaborations, both with other awardees and other donors. The networking that goes with this award, in addition to the funding, makes this award really unique.”

Wouldn’t you rather give a cure than a diagnosis?

Text “BRAIN” to 41518 to donate $10 for research.

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Interested in applying for a 2014 Clinical Research Training Fellowship? Visit AAN.com/view/Fellowships
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Access the sports concussion guideline, resources, and app at aan.com/concussion.
The city is 30 minutes from Tampa on the Gulf of Mexico with 4 weeks’ vacation. Completion of a Neurology residency and salary according to MGMA, a comprehensive benefits package neuroscience unit with outstanding neurology trained nurses. Neurology position in beautiful St. Petersburg, Florida
Larkin (rlarkin@cvph.org) 75 Beekman Street, Plattsburgh, log onto www.northcountrygoodlife.com or contact Rebecca Burlington, VT, and Montreal. For more information please near the Adirondack Mountains, the Olympic-Lake Placid region, program of $150,000. Big hospital, small city on Lake Champlain, Upstate New York—Adirondack BC/BE Neurologist letter to slatif@fmh.org. You can visit our website of Smith Mountain Lake just a short distance away. The “River City by the Sea” boasts more than 20 miles of wide and uncrowded beaches, anything is possible in Jacksonville. The “River City by the Sea” is conveniently located near beautiful white sand beaches. Outstanding financial opportunity. Great on-call schedule. No Call—Coastal Southwest Florida available, but not required. Fort Myers and the Long Beach area. This is also a great opportunity for someone who would like a small city with long traffic woes, and work in a setting surrounded by the medical needs and expertise of the Florida’s Gulf Coast. They are seeking a BC/BE Neurologist to join their team. The University of Toledo Medical Center is a Primary Stroke Center and Vascular Neurology Fellowship starting in July, 2013. The University of Toledo Medical Center is a Non-Profit, full-service, community hospital located on the central coast in beautiful southern Florida. They are looking for a BC/BE Neurologist to join their team. University Health Network is a non-profit, regional, fully integrated network comprised of hospitals, physicians and other related organizations providing care in eastern Pennsylvania. The network includes more than 25 hospitals and 900 physicians. In addition to supporting a diverse administrative and high level of regional among medical staff, there are significant advantages to the Bar Harbor Neurology practice. Mount Desert Island offers access to the island’s cultural resources, social amenities, and world-class public and private schools. Excellent salary and benefits. EOE/AA.

Exciting Opportunity to Provide Help and Hope for Children and Families in the Creation of A New Center for Autism at San Antonio Neurodevelopmental Disorders of Southern California seeks fellowship trained neurologists with special interest in neuro-rehabilitation. AAD and other developmental disorders. This is a collaborative effort between UC Irvine School of Medicine and CHOC Children’s in Orange. Applicants must have interest in translational research, epidemiology or health disparities. The University of Mississippi provides unique opportunities and challenges, as well as fellowship trained neuro-interventional radiologists. For more information, please call Pamela Adams at (610) 969-0213 or pameladarwin@gmail.com.

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