Annual Meeting Education Program Offers Broad and Targeted CME Opportunities

No matter what your interest, career stage, or schedule, the 2014 AAN Annual Meeting—and its extensive Education Program—is a perfect fit. Whether you attend the Annual Meeting for three days or stay for all eight, the Annual Meeting offers a great value for the quality and quantity of programming. With a wide range of course topics to choose from, you can build a targeted subspecialty-specific learning plan or broad learning plan, involving many different topics so you can stay up-to-date on the latest advances in the science and treatment of patients with a variety of neurologic conditions.

Renew Your AAN Membership, Enhance Your Career—At Every Stage

Whether you are a resident just starting out in your career, are in the midst of a career-path change, or are a seasoned neurology professional, your Academy has the tools and resources you need to help you flourish. Membership in the world's largest professional association of neurologists also lends distinction, prestige, and credibility to every stage of your career—all the way through retirement.

Are You in Training?

As a Junior member, you receive the AAN’s clinical practice guidelines, and top science and latest news in the neuroscience community through free subscriptions to Neurology®, Neurology® Clinical Practice, Neurology Today®, and AANnews®. For your training, the Academy offers a complimentary subscription to Continuum: Lifelong Learning in Neurology®—a $308 value alone! And when your training comes to an end, the Neurology Career Center is here to offer one-stop shopping for the latest job postings, interview tools, mentor opportunities, and more.

Are You in Your First Year Out of Training?

For your first year out of training, the AAN significantly discounts your membership to only $150 to make it easier for you to transition and continue your important connection to the benefits that have become such an important part of your career. As you continue on in your new profession, the Academy is here for you with the tools and resources you need for understanding—and fulfilling—your new ABPN-Too Big for One Year! 2014 Practice Management Webinar Series Begins This Month

The AAN’s 2014 Practice Management Webinar series of 15 webinars—including two programs free to AAN members—is so big the Academy is launching it this month with a timely topic of interest to all neurologists and practice managers.

The popular series kicks off on Tuesday, December 17, 2013, with the first free webinar, “Decoding the 2014 Physician Fee Schedule: Changes That Impact Neurology.” William S. Henderson, FACMPE, member of the AAN’s Medical Economics and Management Committee, will lead this 90-minute session online beginning at 12:00 p.m. ET. The deadline to register is Monday, December 16.

The webinar series will continue throughout 2014 and include:

• Decoding the 2014 Physician Fee Schedule: Changes That Impact Neurology*
• Correct Coding for Chemodenervation
• Coding for Neurodiagnostic Procedures Made Easy
• Bundled Payments: The Role for Neurologists in New Health Care Models
• How PQRS Quality Measures Will Inform Future Medicare Value-based Payments

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## News Briefs

Abstract submissions for the 2014 Annual Meeting reached a record high with just over 3,300 abstracts submitted.

More than 550 people attended the Fall Conference, a new record. Attendance at the three practice management courses surpassed last year’s numbers with a total of 268 people attending the practice courses.

The AAN is responding to the House Ways and Means Committee and Senate Finance Committee’s joint proposal to permanently repeal the flawed Sustainable Growth Rate (SGR) formula.

The AAN has drafted measures for the care of patients with muscular dystrophy. These measures will be available for public comment until Monday, December 16, 2013. Visit [AAN.com](http://aan.com) for more information.

The Academy and several other medical societies sent a letter to Health and Human Services Secretary Kathleen Sebelius voicing concerns about CMS’ decision to not exclude articles from medical textbooks and scientific peer-reviewed journals from reporting under the Sunshine Act. The letter requests that CMS reverse its policy because we believe these educational materials directly benefit patients, as physicians consult these resources during patient visits to assist in diagnosis and treatment.
Summit Brings AAN, Subspecialties Closer

In October, during the Fall Conference in Las Vegas, the AAN hosted a half-day Neurology Subspecialty Summit, with the goal of developing a long-term plan that will foster greater interaction and communication among our organizations through identifying key areas for advocacy and other collaborations.

The meeting included leadership representatives from the following neurologic subspecialty organizations:

- American Association of Neuromuscular and Electrodiagnostic Medicine
- American Epilepsy Society
- American Headache Society
- American Society of Neuroimaging
- Child Neurology Society
- The Consortium of Multiple Sclerosis Centers
- Movement Disorders Society
- Neurocritical Care Society
- North American Neuro-ophthalmology Society
- Society for Behavioral and Cognitive Neurology
- United Council for Neurologic Subspecialties

The summit provided a forum for leaders of these organizations to engage in candid and focused discussions about the various challenges affecting the field of neurology, the members of our organizations, and the patients we serve. The participants divided into breakout sessions to discuss three main topics and propose possible action items for consideration:

Subspecialty Work Force Issues

There is a need to distinguish clearly between subspecialties and sections. The role of the AAN sections is strictly limited to education and research, and a priority is to determine if an infrastructure is needed for improved communication and raising subspecialty advocacy and other issues to the AAN. We need to reduce duplicative efforts and better coordinate our messages to CMS, building on the strength of the AAN’s advocacy skills and connections. The Academy will investigate assisting subspecialties that don’t have the infrastructure to complete this work.

Other potential action items that were identified by this breakout session included: Attracting medical students into neurology (third year or earlier); providing a stronger focus for neurology advanced practice providers into the AAN as has been done in a number of subspecialty organizations; and development of business models to improve the financial stability of some neurology subspecialties.

Funding for GME

All agreed that a declining neurology work force would result in: Shifting neurology patients to care by family physicians and internists; hiring more advanced-practice providers; having more shifts covered by attending neurologists; and possibly outsourcing neurologic care to foreign medical graduates.

Possible cuts to support for graduate medical education (GME) would most affect: Larger states because they rely most heavily on GME and residency programs to provide care; public hospitals, which the group agreed would not be able to absorb GME funding cuts of more than 10 percent; and needy populations, which would be disproportionately affected. In addition, teaching hospitals would be disproportionately affected because of the inherent inefficiency associated with postgraduate medical training as well as the substantial infrastructure needed to support training programs. The AAN needs to be more proactive and make contingency plans in the event GME cuts occur by creating strategic partnerships, planning now to prepare for worst case scenarios, and laying solid groundwork for a strong grassroots campaign that could include patient participation.

The Role of Subspecialties in Value-based Health Care Delivery

Discussions began with how value, quality, and expense are defined by stakeholders. Suggestions for influencing how quality is measured included having greater AAN input on what CMS defines as quality metrics, and a push to develop longer-term quality metrics than those the Academy currently promotes.

In the end, the main outcomes of this first subspecialty summit stressed the need for a better understanding of the role of subspecialties within neurology and their relation to the AAN, the importance of collaboration and sharing our expertise with one another around common issues and challenges, and speaking with one voice, particularly in our advocacy activities, including support for GME and metrics for value-based health care delivery. This summit has emphasized the need for a regular and continuing dialog between the AAN and the neurology subspecialties. It also has set the stage for us to define and seize new opportunities that will collectively strengthen the future of our memberships and improve the care of our patients.

Timothy A. Pedley, MD, FAAN
President, AAN
Last Chance to Earn 0.5-percent Medicare eRx Incentive Bonus

December 31 is the deadline to earn the 2013 incentive payment of 0.5 percent from the Medicare Electronic Prescribing (eRx) Incentive Program. This is the last year the program will provide an incentive payment for participating.

To successfully report under the 2013 eRx Incentive Program, neurologists must generate at least one eRx associated with a patient visit on 25 or more unique events during the 2013 calendar year using the G-code G8553.

2014 will be the last calendar year that an eRx penalty will be applied for not participating. The six-month 2013 eRx reporting period (January 1, 2013, through June 30, 2013) was the final reporting period to avoid the 2014 penalty.

Visit www.aan.com/practice/medicare/electronic-prescribing-incentive-program for the latest information and details on eligibility and how to earn the incentive, including other reporting mechanisms.

Magazines Deliver Powerful Stories to Readers

In this month’s Neurology® Clinical Practice, the brave new world of manipulating the nervous system is explored. “This issue features articles on transcranial magnetic stimulation and non-mydriatic retinal photography, and over the course of coming months we will have articles on baclofen pumps, vagal nerve stimulators, functional electrical stimulators for muscle activation, spinal stimulators for pain relief, and others. In addition, we will deliver an update on the potential uses of stem cells in neurologic diseases,” said Editor John R. Corboy, MD, FAAN.


Neurology: Clinical Practice, published six times a year, is available in print (for US members only), online, and for the iPad. Visit www.neurology.org/cp for more information.

In Neurology Now®, country music star Glen Campbell’s wife, Kimberly Woollen, talks about their lives both before and after his diagnosis of Alzheimer’s disease in 2011 and his poignant “Goodbye Tour” with three of his children joining him in his backup band. Other stories address how traumatic brain injury can take a toll on relationships and what experts advise on staying connected, and Michael J. Fox’s new TV series in which he stars as a news anchor, husband, and father living with Parkinson’s disease. Fox is also the host of the AAN’s new patient education DVD, sharing his insights on the disease he’s lived with for 22 years.

Visit www.NeurologyNow.org for more information about Neurology Now, the AAN’s free bimonthly magazine for neurology patients, their families, and caregivers. AAN members receive 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.

Power Your Practice: Expect These PQRS Changes in 2014

Changes are in store for the 2014 Physician Quality Reporting System (PQRS). This will be the last year to earn an incentive payment. Eligible professionals (EPs) who do not report in 2014 will incur a two-percent penalty on their Medicare payments beginning in 2016.

There is still time to qualify for the incentive and avoid the penalty. Practices have until February to submit 2013 data to avoid the 2015 penalty. EPs can use as few as one individual measure to avoid the penalty.

The AAN is partnering with CECity PQRTwizard to provide members with an easy way to rapidly collect, validate, report, and submit the results to the Centers for Medicare & Medicaid Services for payment.

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 on the following pages.
FOCUS ON EVERY DAY

AUBAGIO® (teriflunomide)—a once-daily oral therapy for relapsing forms of MS

EFFICACY

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

ADDITIONAL IMPORTANT SAFETY INFORMATION

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 coadministering 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). If drug-induced liver injury is suspected, discontinue use of AUBAGIO, start accelerated elimination, and monitor liver tests weekly until normalized.

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. 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 in some patients, to reach plasma concentrations <0.02 mcg/mL. Elimination may be accelerated by administration of cholestyramine or charcoal, but this may cause disease activity to return in patients who were responding to AUBAGIO.

Decreases in white blood cell counts, mainly of neutrophils and lymphocytes, and platelets have been reported with AUBAGIO. Obtain a complete blood cell 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 skin test. Treatment in patients with acute or chronic infections should not be started until the infection(s) is resolved.

Please see Brief Summary of Full Prescribing Information, including boxed WARNING.
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 polynuropathy 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, have been reported with AUBAGIO. Monitor renal function and potassium if symptoms of acute renal failure or hyperkalemia appear.

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 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 paresthesia (9% and 10% vs 8%).

**Drug Interactions:** Monitor patients when teriflunomide is coadministered with warfarin or drugs metabolized by CYP1A2 or CYP2C8.

**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 and 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.
FOCUS ON EVERY DAY

AUBAGIO® (teriflunomide)—a once-daily oral therapy for relapsing forms of MS

**EFFICACY**

**EFFICACY demonstrated in the 2-year pivotal trial**

- Statistically significant reductions with AUBAGIO 14 mg in annualized relapse rate (ARR), risk of sustained disability progression,† and MRI total lesion volume‡
  - The 7 mg dose of AUBAGIO achieved statistically significant reductions in ARR and MRI total lesion volume but not in sustained disability progression

**SAFETY PROFILE**

**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, respectively, were alanine aminotransferase (ALT) increases (14%, 12%, and 7%), alopecia (13%, 10%, and 3%), diarrhea (18%, 15%, and 9%), influenza (12%, 9%, and 10%), nausea (14%, 9%, and 7%), and paresthesia (10%, 9%, and 8%)²

- Similar proportions of patients in the AUBAGIO 14 mg and 7 mg and placebo groups had serious adverse events (AEs) (15.9%, 14.1%, and 12.8%, respectively)¹

- Overall discontinuation rate due to AEs was 10.9% with AUBAGIO 14 mg, 9.8% with AUBAGIO 7 mg, and 8.1% with placebo¹

**ONCE-DAILY oral dosing**²

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

¹In a double-blind, placebo-controlled Teriflunomide Multiple Sclerosis Oral (TEMSO) study, 1088 patients with relapsing forms of MS were randomized to receive AUBAGIO 14 mg (n=359) or 7 mg (n=366) or placebo (n=363) once daily for 108 weeks.²

²Sustained 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 weeks.

³Defined as the total volume of all abnormal brain tissue; calculated as the sum of the total volume of the T2 lesion component and the T1 hypointense lesion component (prespecified end point).

AUBAGIO is contraindicated in patients with severe hepatic impairment, in pregnant women, in women of childbearing potential who are not using reliable contraception, and in patients currently taking leflunomide.

Please see brief summary of Full Prescribing Information, including boxed WARNING regarding hepatotoxicity and use in pregnancy.


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1. 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].

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 (5.2)].
- 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 [see Warnings and Precautions (5.4)],.
- Check blood pressure before start of AUBAGIO treatment and periodically thereafter [see Warnings and Precautions (5.9)],

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 pregnant woman. In animal studies, teriflunomide has been shown to be selectively teratogenic and embryotoxic in multiple species when administered prenatally at doses less than those used clinically. Nonclinical studies indicate that the intended pharmacological effect of the drug is involved in the mechanism of developmental toxicity [see Use in Specific Populations (8.1)].

AUBAGIO is contraindicated in women who are pregnant or women of child bearing potential not using reliable contraception. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to a fetus. AUBAGIO is contraindicated in pregnant women and women of child bearing 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 [see Contraindications (4.2), Warnings and Precautions (5.2), and Use in Specific Populations (8.1)].

5. WARNINGS AND PRECAUTIONS

5.1 Hepatotoxicity
Severe liver injury including fatal liver failure and dysfunction has been reported in some patients treated with leflunomide, which is indicated for rheumatoid arthritis. A similar risk would be expected for teriflunomide because recommended doses of teriflunomide and leflunomide result in a similar range of plasma concentrations of teriflunomide. Concomitant use of AUBAGIO with other potentially hepatotoxic drugs may increase the risk of severe liver injury. Obtain transaminase and bilirubin levels within 6 months before initiation of AUBAGIO therapy. Monitor ALT levels at least monthly for six months after starting AUBAGIO [see Warnings and Precautions (5.2)]. 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 treatment or prior to the completion of an accelerated elimination procedure after AUBAGIO treatment [see Contraindications (4.2), Warnings and Precautions (5.2), and Use in Specific Populations (8.1)].

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.

Patients with pre-existing acute or chronic liver disease, or those with serum alanine transaminase (ALT) levels 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 14/429 (3%) and 21/415 (5%) of patients on teriflunomide 7 mg and 14 mg, respectively, and 17/421 (4%) of patients on 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. Teriflunomide-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. Consider additional monitoring when AUBAGIO is given with other potentially hepatotoxic drugs. Consider discontinuing AUBAGIO if serum transaminase increase greater than three times the ULN is confirmed. Monitor serum transaminase and bilirubin on AUBAGIO therapy, particularly in patients who develop symptoms suggestive of hepatic dysfunction, such as unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine. If liver injury is suspected to be AUBAGIO-induced, discontinue teriflunomide and start an accelerated elimination procedure [see Warnings and Precautions (5.3) and monitor liver tests weekly until normalized. If teriflunomide-induced liver injury is unlikely because some other probable cause has been found, resumption of teriflunomide therapy may be considered.

5.3 Procedure for Accelerated Elimination of Teriflunomide
Teriflunomide is eliminated slowly from the plasma. Without an accelerated elimination procedure, it takes on average 6 months to reach plasma concentrations less than 0.02 mg/L, although because of individual variations in drug clearance it may take as long as 2 years. An accelerated elimination procedure could be used at any time after discontinuation of AUBAGIO.

Elimination can be accelerated by either of the following procedures:
- Administration of cholestyramine 8 g every 8 hours for 11 days. If cholestyramine 8 g three times a day is not well tolerated, cholestyramine 4 g three times a day can be used.
- Administration of 50 g oral activated charcoal powder every 12 hours for 11 days.

If either elimination procedure is poorly tolerated, treatment days do not need to be consecutive unless there is a need to lower teriflunomide plasma concentration rapidly.

5.4 Bone Marrow Effects/Immunosuppression Potential/Infections

White Blood Cell (WBC) count decrease
- In placebo-controlled trials with 7 mg and 14 mg of AUBAGIO, the decrease in mean WBC count occurred 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 (5.9)],

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

5.5. Bone Marrow Suppression

Risk of Infection / Tuberculosis Screening
Patients with active acute or chronic infections should not start treatment until the infection(s) 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 infection to a physician.

AUBAGIO is not recommended for patients with severe immunodeficiency, bone marrow disease, or severe, uncontrolled infections. Medications like teriflunomide 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 teriflunomide 7 mg (1.4%) or 14 mg (2.2%) compared to placebo (2.1%).
However, one fatal case of klebsiella pneumonia sepsis occurred in a patient taking teriflunomide 14 mg for 17 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. AUBAGIO has not been studied in patients with a positive tuberculin screen, and the safety of AUBAGIO in individuals with latent tuberculosis infection is unknown. For patients testing positive in tuberculin screening, treat by standard medical practice prior to therapy with AUBAGIO.

**Vaccination**

No clinical data are available on the efficacy and safety of vaccinations in patients taking AUBAGIO. Vaccination with live vaccines is, however, 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 immunosuppressive medications. There is a potential for immunosuppression with teriflunomide. 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), was reported more frequently in patients taking AUBAGIO than in patients taking placebo. In one 108-week placebo-controlled study in 1086 patients, the incidence of peripheral neuropathy (peripheral nerve conduction studies was 1.2% (4 patients) and 1.9% (6 patients) on 7 mg and 14 mg of AUBAGIO, respectively, compared with 0% on placebo. Treatment was discontinued in 2 patients with polyneuropathy, one on each dose; one of them recovered following treatment discontinuation. The other cases of peripheral neuropathy did not resolve with continued treatment. There have also been reports of peripheral neuropathy in patients receiving leflunomide. Age older than 60 years, concomitant neurotoxic medications, and diabetes may increase the risk for peripheral neuropathy. If a patient taking AUBAGIO develops any of these conditions, stop AUBAGIO therapy and perform an accelerated elimination procedure [see Warnings and Precautions (5.3)].

**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)]
- **Acute Renal Failure** [see Warnings and Precautions (5.6)]
- **Hyperkalemia** [see Warnings and Precautions (5.7)]
- **Serious Skin Reactions** [see Warnings and Precautions (5.8)]
- **Blood Pressure Effects** [see Warnings and Precautions (5.9)]
- **Respiratory Effects** [see Warnings and Precautions (5.10)]

The most frequent adverse reactions for AUBAGIO (incidence ≥10% and ≥2% greater than placebo) in the placebo-controlled studies were ALT increased, alopecia, diarrhea, influenza, nausea, and pancreatitis. Alopecia was the most common cause of discontinuation because of adverse events in controlled clinical studies as compared to placebo (0.5% and 1.4% of patients on AUBAGIO 7 mg and 14 mg, respectively, and 0% on placebo)

If desired, teriflunomide can be rapidly cleared by the body from the use of an accelerated elimination procedure [see Warnings and Precautions (5.3)].

**6.1 Clinical Trial Experience**

A total of 844 patients on teriflunomide (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 MS (RMS). Approximately 72% of patients were female and the mean age was 38 years. Study 1 was a 108-week placebo-controlled clinical study in 1086 RMS patients treated with teriflunomide 7 mg (n=368), teriflunomide 14 mg (n=358), or placebo (n=360). 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.

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

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<th>PRIMARY SYSTEM ORGAN CLASS</th>
<th>Teriflunomide</th>
<th>Placebo</th>
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<tbody>
<tr>
<td>Preferred Term (%)</td>
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<tr>
<td>14 mg (N=358)</td>
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<tr>
<td>7 mg (N=368)</td>
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<td>Placebo (N=360)</td>
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**7.3, and >7.0 mmol/L occurred in 8/829** patients, and reported

**7.0 mmol/L occurred in 8/829 patients, and reported

**Acute Renal Failure** [see Warnings and Precautions (5.6)]

**Hyperkalemia** [see Warnings and Precautions (5.7)]

**Serious Skin Reactions** [see Warnings and Precautions (5.8)]

**Blood Pressure Effects** [see Warnings and Precautions (5.9)]

**Respiratory Effects** [see Warnings and Precautions (5.10)]

The most frequent adverse reactions for AUBAGIO (incidence ≥10% and ≥2% greater than placebo) in the placebo-controlled studies were ALT increased, alopecia, diarrhea, influenza, nausea, and pancreatitis. Alopecia was the most common cause of discontinuation because of adverse events in controlled clinical studies as compared to placebo (0.5% and 1.4% of patients on AUBAGIO 7 mg and 14 mg, respectively, and 0% on placebo).

If desired, teriflunomide can be rapidly cleared by the body from the use of an accelerated elimination procedure [see Warnings and Precautions (5.3)].

**6.1 Clinical Trial Experience**

A total of 844 patients on teriflunomide (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 MS (RMS). Approximately 72% of patients were female and the mean age was 38 years. Study 1 was a 108-week placebo-controlled clinical study in 1086 RMS patients treated with teriflunomide 7 mg (n=368), teriflunomide 14 mg (n=358), or placebo (n=360). 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.

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

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<td>Placebo (N=360)</td>
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</table>

**INFECTIONS AND INFESTATIONS**

- **Influenza** 12% 9% 10%
- **Upper respiratory tract infection** 9% 9% 7%
- **Bronchitis** 8% 5% 6%
- **Sinusitis** 6% 4% 4%
- **Cystitis** 4% 2% 1%
- **Gastroenteritis viral** 4% 2% 1%
- **Oral herpes** 4% 2% 2%

**BLOOD AND LYMPHATIC SYSTEM DISORDERS**

- **Neutropenia** 4% 2% 0.3%
- **Leukopenia** 1% 2% 0.3%

**IMMUNE SYSTEM DISORDERS**

- **Seasonal allergy** 3% 2% 1%

**PSYCHIATRIC DISORDERS**

- **Anxiety** 4% 3% 2%

**NERVOUS SYSTEM DISORDERS**

- **Headache** 19% 22% 18%
- **Parasthesia** 10% 9% 8%
- **Sciatia** 3% 1% 1%
- **Burning sensation** 3% 2% 1%
- **Carpal tunnel syndrome** 3% 1% 0.3%
- **VISUAL DISORDERS**
- **Vision blurred** 3% 3% 1%
- **Conjunctivitis** 1% 3% 1%
- **CARDIOVASCULAR DISORDERS**
- **Palpitations** 2% 3% 1%
In clinical trials, 18% of teriflunomide-treated subjects had mild hypophosphatemia (≥0.3 mmol/L and <lower limit of normal), compared to 9% of placebo-treated subjects; 5% of teriflunomide-treated subjects had moderate hypophosphatemia (0.6 mmol/L and <0.3 mmol/L), compared to 1% of placebo-treated subjects. No subject in either treatment group had a serum phosphorus <0.3 mmol/L.

7. DRUG INTERACTIONS

Effect of teriflunomide on CYP2C8 substrates

There was an increase in mean repaglinide Cmax and AUC (1.7- and 2.4-fold, respectively), following repeated doses of teriflunomide and a single dose of 0.25 mg repaglinide, suggesting that teriflunomide is an inhibitor of CYP2C8 in vivo. The magnitude of interaction could be higher at the recommended repaglinide dose. Therefore, monitoring patients with concomitant use of drugs metabolized by CYP2C8, such as repaglinide, pacitaxel, pioglitazone, or rosiglitazone is recommended as they may have higher exposure.

Effect of teriflunomide on warfarin

A 25% decrease in peak international normalized ratio (INR) was observed when teriflunomide was coadministered with warfarin as compared with warfarin alone. Therefore, when warfarin is coadministered with teriflunomide, close INR follow-up and monitoring is recommended.

Effect of teriflunomide on oral contraceptives

There was an increase in mean ethinylestradiol Cmax and AUC (1.56- and 1.54-fold, respectively) and levonorgestrel Cmax and AUC (1.53- and 1.41-fold, respectively) following repeated doses of teriflunomide. Consideration should be given to the type or dose of oral contraceptives used in combination with teriflunomide.

Effect of teriflunomide on CYP1A2 substrates

Repeated doses of teriflunomide decreased mean Cmax and AUC of caffeine (CYP1A2 substrate) by 18% and 55% respectively, suggesting that teriflunomide may be in vivo a weak inducer of CYP1A2. Therefore, patients should be monitored when teriflunomide is coadministered with drugs metabolized by CYP1A2 (such as duloxetine, almotriptan, losartan, and lamotrigine), as the efficacy of such drugs could be reduced.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C [see Contraindications (4.2) and Warnings and Precautions (5.2)]. When teriflunomide (oral doses of 1, 3, 5, or 12 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).

8.2 Lactation

Although AUBAGIO is contraindicated in pregnancy, a pregnancy registry has been established to monitor fetal outcomes of pregnant women exposed to AUBAGIO. Physicians are encouraged to enroll pregnant women in the AUBAGIO pregnancy registry, or pregnant women may enroll themselves, by calling 1-800-745-4447, option 2.

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, moderate, and severe hepatic impairment. The pharmacokinetics of teriflunomide in severe hepatic impairment have not been evaluated.

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)].
Michael J. Fox Hosts New AAN Video on Parkinson’s Disease

Actor and Parkinson’s disease advocate Michael J. Fox hosts Parkinson’s Disease: A Guide for Patients and Families, a new patient education video produced by the AAN that is now available free to members and the public either on DVD or online.

The video features two Academy member experts on this disease, Kathleen M. Shannon, MD, and Stanley Fahn, MD, FAAN, former president of the AAN.

Fox also is featured in a story for the December 2013/January 2014 issue of Neurology Now®. The actor is starring in a new television series about a New York City news broadcaster living with Parkinson’s disease.

Parkinson’s Disease: A Guide for Patients and Families is available to AAN members and patients at no charge while supplies last. Free DVD copies can be ordered by calling (800) 879-1960. To download the free DVD and guidebook, visit www.aan.com/view/PatientEducationVideos.

The DVD also can be viewed online at www.YouTube.com/AANChannel with other patient education DVDs produced by the AAN discussing epilepsy, multiple sclerosis, diabetic nerve damage, and Alzheimer’s disease.

Too Big for One Year! 2014 Practice Management Webinar Series Begins this Month

Continued from cover

• Measuring and Improving Your Patients’ Experience
• Using Practice Benchmarking Analytics to Improve Your Bottom Line
• ICD-10: Are You Ready? Ensure Your Practice Does Not Receive Payment Interruptions*
• Protecting the Solo and Small Practice Neurologist
• Accountable Care Organizations: The Role of Neurologists in New Health Care Models
• E/M: Minimize Mistakes, Maximize Reimbursement
• How Is Your Care Measuring Up?
• Working Effectively with Advanced Practice Providers
• Achieving Stage 2 Meaningful Use: Taking Your EHR Use to the Next Level
• Quality Improvement: Beginning Steps in the Right Direction

*Free to all AAN members; $99 for all nonmembers.

With the exception of the two free webinars, the cost to participate is $149 for one webinar or a new “buy all” rate of $199 for access to all webinars. Purchasing the webinar grants you access to both the live event and recording of the webinar. Slides are included with all webinar purchases.

For more information, including dates and speakers, visit www.aan.com/practice/practice-management-resources or contact Elizabeth Bradshaw at ebradshaw@aan.com.
Academy Joins “Speak Up” Campaign for Memory Problems, Dementia

The AAN is participating in The Joint Commission’s new public safety campaign, Speak Up: What You Need to Know About Memory Problems and Dementia. Academy members can participate by sharing a new free brochure, offered in either English or Spanish, with their patients and their families.

The Joint Commission invites other organizations to collaborate on Speak Up campaigns to ensure that the messages provided to consumers about how to get involved in their health care are consistent, accurate, and specific. David S. Knopman, MD, FAAN, and Richard B. Lipton, MD, FAAN, represented the AAN in the content development process.

To download the brochures, visit The Joint Commission at www.jointcommission.org/speakup_memory_problems. For more information on The Joint Commission’s Speak Up campaigns, visit www.jointcommission.org/speakup.aspx.

And remember, the AAN offers free online PDF files of its own exclusive series of patient brochures, including Alzheimer’s disease, as well as discounted packages of pre-printed brochures for members. Visit The AAN Store® to learn more at www.aan.com/store.
AAN Leads Development of Dementia Management, ALS Quality Measures

The AAN led the development of two quality improvement measurement set papers that were recently published in Neurology®. The Dementia Measures measure development work group was led by AAN member Germaine Odenheimer, MD, FAAN, and American Geriatrics Society member Jerry Johnson, MD. The paper based upon the measurement set is focused on 10 quality measures for the management of patients diagnosed with dementia. Nine of these measures are included in the 2013 Physician Quality Reporting System measure list and one dementia measure is included in Meaningful Use Stage 2 list of approved measures. The paper was published online on September 25, 2013, and was published in Neurology on October 22, 2013.

The AAN also led the development of 11 quality measures for the care and management of patients with amyotrophic lateral sclerosis (ALS). The measure development work group and the author panel were led by AAN members Robert G. Miller, MD, FAAN, and Benjamin Rix Brooks, MD. All of the AAN ALS measures have been incorporated into a new ALS registry led by the Muscular Dystrophy Association. The paper was published online on November 22, 2013, and will be published in Neurology on December 10, 2013.

Members are encouraged to implement these measures into their practices to demonstrate the quality of care they provide and, in the case of the dementia measures, also meet the PQRS requirements. For more information, contact Rebecca J. Swain-Eng, MS, CAE, at rsaineng@aan.com or (612) 928-6121.

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/view/hillreport. Below are some recent highlights.

Bipartisan/Bicameral SGR Repeal Bill Released

The House Ways & Means Committee and the Senate Finance Committee jointly authored an outline of a bill that would permanently repeal the Sustainable Growth Rate (SGR) formula and replace it with a system of alternative physician payment models to be developed over the next few years. Payments would be frozen at current levels until 2023 while alternatives are tested. Starting in 2017, a “value-based performance” program would tie payments to the quality of treatment and other performance metrics. We are initially concerned with a ten-year freeze on payments, but it seems this is unlikely to change as any positive payment update swells the cost of the bill, which starts at $139 billion just to eliminate the SGR. The idea is that physicians who show quality and value will be eligible for payment updates above what would be seen if Congress just continues to step in and temporarily patch the SGR, as it has done for almost the last decade. The Academy is committed to ensuring that any efforts to pay for care coordination and other “primary care” services apply equally to cognitive specialists like neurologists.

NIH Funding Decline Continues

The federal “sequestration” budget cuts continue to impact the NIH budget, now funding proposals at a record low of just 17 percent. The AAN sent out an action alert to members asking them to contact Congress to stress the importance of maintaining funding for research. Send your letter at www.aan.com/public-policy/contact-your-legislator.
Education Program Offers Broad and Targeted CME Opportunities

Continued from cover

2014 Education Program topic areas are:
• Aging, Dementia, Cognitive, and Behavioral Neurology
• Cerebrovascular Disease and Interventional Neurology
• Child Neurology and Developmental Neurology
• Epilepsy/Clinical Neurophysiology (EEG)
• General Neurology
• Global Health and Infectious Disease
• Headache
• Movement Disorders
• MS and CNS Inflammatory Disease
• Neuro Trauma, Critical Care, and Sports Neurology
• Neuromuscular and Clinical Neurophysiology (EMG)
• Neuro-oncology
• Neuro-ophthalmology/Neuro-otology
• Neuro-rehabilitation
• Pain and Palliative Care
• Practice, Policy, and Ethics
• Research Methodology, Education, and History
• Sleep

Find more online at www.aan.com/view/SearchAM.

Get More Out of the Education Program

New This Year! Buy All Option

Interested in attending more than just a few education courses? The new Buy All registration option may be for you. For one flat rate, you can register for the Annual Meeting and gain access to all* the excellent Education courses—all week long. A great value in CME programming!

NeuroSAE®: Annual Meeting Edition—FREE to AAN members!

Earning 10 FREE self-assessment CME credits and planning your 2014 Annual Meeting course schedule is easy with the AAN’s latest online self-assessment examination in neurology.

1. Visit www.aan.com/view/SAE14 to take the online pre-test by April 25, 2014, and assess your knowledge.
2. Build your Annual Meeting CME learning plan based on your pre-test score report and recommendations for courses at the 2014 Annual Meeting.
3. Register for the Annual Meeting, or adjust your existing course schedule as needed.
4. After attending the meeting, gauge your improvement by completing the online post-test by August 5, 2014.
5. Earn a score of 70 percent or higher and receive 10 FREE self-assessment CME credits.

* Skills Workshops and Skills Pavilions excluded from Buy All pricing. Attendee must identify courses to be included as part of “Buy All” purchase. Courses are subject to closure due to reaching maximum capacity. Buy All registration option is only available prior to early registration deadline of April 3, 2014.
New Program Builds Women’s Leadership Capacity

More than 50 percent of physicians and trainees in neurology today are women. Yet women remain underrepresented in the top leadership positions in academic medical centers or large private practice. Current research indicates that women’s strengths and styles are more necessary than ever for institutions to be successful, and balancing women’s and men’s voices “at the table” often creates stronger results.

In response, the Academy has created a new program debuting at the 2014 Annual Meeting in Philadelphia that will provide an opportunity for female attendees to learn from successful women members in the field of neurology, including members of the AAN Board of Directors, about how to lead at senior levels.

The full-day course will take place from 9:00 a.m. to 5:00 p.m. on Monday, April 28, and participation is by selection through an application process only. Directors Allison Brashear, MD, MBA, FAAN; Barbara Hoebe, principal president of The Inventure Group; and a panel of other expert presenters will share how they overcome challenges to achieve leadership success. Participants will learn to apply knowledge to roles as a leader in the hospital, community, state medical society, professional organizations, and political action. The course will not offer CME credit. Selected recipients will receive complimentary registration for this course.

Women who are talented, highly motivated AAN members with a commitment to neurology are encouraged to submit their CV and a short statement about why they would benefit from attending the program by the March 7, 2014, deadline. Space is limited, so visit www.aan.com/view/WomenLead to apply today.

Other Leadership Development Opportunities Open to All at the 2014 Annual Meeting

Whether you want to be a mentor or an advocate, to guide or inspire others, these programs can help you cultivate the skills to be an effective leader.

Life Reimagined
Sunday, April 27
8:00 a.m.–12:00 p.m.
Director: Richard Leider, Founder, The Inventure Group, Minneapolis, MN
Are you at a point in your life where you are asking, “What’s next?” You’ve finished one chapter and have not written the next. Many of us face these transitions at midlife but they can happen at any point. It’s a time of enormous potential and it defines a whole new phase of life. It’s called a Life Reimagined.

Improving Your Leadership Skills: A Practical Approach
Monday, April 28
1:00 p.m.–5:00 p.m.
Directors: Terrence L. Cascino, MD, FAAN, Rochester, MN; Ralph L. Sacco, MD, MS, FAHA, FAAN, Miami, FL
Leadership has been defined as “having a sound vision and convincing others to follow you.” This course will assist you in implementing the vision and offer practical tips and case examples on how to persuade others to follow.
Coming Soon

40 mg/1 mL

COPAXONE®
(glatiramer acetate injection)
40 mg/1 mL

Get ready at copaxone40.com.

COPAXONE® is a registered trademark of Teva Pharmaceutical Industries Ltd.
© 2013 Teva Neuroscience, Inc. COP-40525
Convenient Online Learning Programs Can Help You Meet Your Year-end CME Needs

Need important CME credits before the end of the year? The AAN offers a variety of exclusive—and convenient—online learning programs to help you meet your end-of-year CME needs, and take the necessary steps towards completing your maintenance of certification (MOC) requirements.

NeuroPl℠
The AAN’s online performance improvement program meets the ABPN MOC Part 4 Performance in Practice component requirements in addition to offering 20 CME credits. Two new ALS modules are now available within the NeuroPl suite of excellent programs, all designed to help you improve your care strategies.

NeuroSAE®
The AAN’s convenient online self-assessment examination assesses your knowledge of neurology to assist you in building your learning plan and compares your performance to other neurologists. The Sixth Edition is now available featuring 150 questions and eight self-assessment CME credits upon successful completion.

NeuroLearn℠
The AAN’s exclusive multimedia suite of online education courses is designed to be taken at your own time and pace. These courses address relevant clinical neurology and timely practice topics, and offer up to two CME credits upon successful completion. The latest addition is “Recurrent Ischemic Stroke Prevention.”

Continuum: Lifelong Learning in Neurology®
The AAN’s self-study journal provides up to 14 hours of AMA PRA Category 1 Credits® per issue. Assess your knowledge online, on your mobile device, and in print. Continuum® is approved to meet the ABPN self-assessment and continuing medical education requirement for MOC. Available in print and online.

Continuum Audio
Continuum Audio includes probing discussions with authors of selected articles published in Continuum. These conversations focus on actual case studies and emphasize important aspects 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 1 Credits per program (or up to 48 per year).

Practice Management Webinars
Through Practice Management Webinars, you can earn CME while getting the latest coding information or staying current with health care changes that impact your practice. Each webinar offers 1.5 AMA PRA Category 1 Credits.

Patient Safety Online CME: “Recognizing Abuse in Your Neurology Patients”
This important module offers one CME credit and covers the prevalence of abuse, the different types of abuse, methods of screening, and ways to respond to a patient who discloses abuse.

Neurology®
Stay current with the most recent advances in the field with Neurology, the AAN’s peer-reviewed, premier medical journal. Go online to earn up to 1.5 hours of AMA PRA Category 1 Credits per issue—or up to 72 for a full year. Available in print and online.

Neurology Podcast
Earn .5 AMA PRA Category 1 Credit when you listen to weekly podcasts from Neurology and answer the accompanying online questions.


Track Your Education Effortlessly with NeuroTracker™!
Wondering how many MOC credit requirements you need to complete by the end of the year—and looking for suggestions on the best resources to help you complete those requirements? Visit NeuroTracker on AAN.com to quickly and easily assess your MOC progress and get the best recommendations to fulfill your needs.

Reminder: NeuroTracker has been upgraded to sync with ABPN Physician Folios, eliminating the need for members to make duplicate entries from NeuroTracker to the ABPN. In order to activate the new functionality and allow NeuroTracker to share data with the ABPN, AAN members must log in to NeuroTracker at www.aan.com/view/neurotracker and check a box allowing for the data exchange.
Muscle diseases from muscular dystrophies to myopathies are reviewed in the latest issue of *Continuum: Lifelong Learning in Neurology®,* which offers participants an opportunity to earn up to 14 hours of AMA PRA Category 1 Credits™.

“In this issue, we present the common symptoms, diagnostic tests, and approach to therapy associated with muscle diseases to allow the neurologist to begin appropriate work-up, counsel families regarding differential diagnosis, and make appropriate referrals to a neuromuscular center,” said Guest Editor Carlayne E. Jackson, MD, FAAN, with the University of Texas Health Science Center in San Antonio. “Although disease-altering therapies have proven elusive for many muscle diseases, a multimodal approach to the care of these patients can markedly improve their quality of life.”

Articles cover congenital muscular dystrophies and congenital myopathies, muscular dystrophies, metabolic myopathies, muscle channelopathies, inflammatory myopathies, and toxic myopathies.

The ethical perspectives article looks at the new frontier of genetically targeted therapies for muscle disease. Two practice articles address administration of glucocorticoids in boys with Duchenne muscular dystrophy and CPT and ICD-9-CM and ICD-10-CM coding issues for neuromuscular visits.

Upon completion of the issue, participants will be able to:

- Recognize the signs and symptoms of congenital muscular dystrophies and congenital myopathies in infancy and early childhood
- Define the clinical features associated with the muscular dystrophies and use these clinical features to diagnose genetic muscle diseases
- Describe the clinical presentation, mechanisms, and treatment of metabolic myopathies
- Recognize episodic muscle symptoms and signs associated with inherited muscle channelopathies
- Identify the clinical, laboratory, histopathology, and pathogenic bases of dermatomyositis, polymyositis, immune-mediated necrotizing myopathy, and inclusion body myositis, as well as methods to treat these disorders
- Recognize and treat myopathy caused by prescription medications and other potential myotoxins
- Formulate a multidisciplinary approach to the individual with a myopathy that is centered on strength therapies, symptomatic therapies, supportive care, and psychological support
- Generate a differential diagnosis in a patient with a suspected myopathy based on his or her specific distribution of weakness and unique clinical signs and symptoms
- Discuss some of the ethical considerations involved for families faced with enrolling a minor child in clinical trials of sophisticated, expensive therapies, including the balance of risks versus benefits, proper consent and assent, and potential conflicts of interests on the part of the investigators

*Continuum* is the AAN’s highly regarded and convenient CME review journal. With a total of 84 CME credits available annually, *Continuum* is published six times per year and includes a self-assessment pretest, multiple-choice question examination, and a patient management problem. Subscribers access CME online by visiting www.aan.com/continuum/cme, where they may complete the self-assessment and CME activities and receive CME credits within two business days. Subscribe to *Continuum* today by contacting Lippincott Williams & Wilkins at (800) 361-0633, (301) 223-2300 (international), or www.lww.com/continuum. Junior members who are transitioning to Active or Associate memberships are eligible to receive a 50-percent discount on the already low member rate for *Continuum* subscriptions.
AAN Videos Promote Neurology, Academy via YouTube

For several years, the AAN has self-produced videos to help get the word out to members about various products or services the organization offers. The ability to do this has been upgraded recently thanks to the publisher of the AAN's leading professional journals.

“Videos are an important part of the Academy’s communications to members,” said AAN Executive Director and CEO Catherine M. Rydell, CAE. “They help members connect with both the message of the video and the personalities of Academy leaders and neurology experts who often are the faces and voices of the profession.”

The AAN’s video efforts have improved due to an innovation grant from Lippincott Williams & Wilkins, publisher of the AAN’s scientific journal *Neurology®, Neurology® Clinical Practice, Neurology Now®,* *Neurology Today®,* and *Continuum®*. The grant has enabled the Academy to purchase equipment for recording both videos and audio clips for broadcast.

“We work with a lean marketing budget and we can’t send staff to all corners of the country to film our leadership. So, having the right equipment means we can be ready any time Academy leaders, Annual Meeting program directors, or other key members visit our Minneapolis offices for meetings,” said Rydell. “Our staff is very nimble and we can accomplish quite a bit on short notice and still deliver a professional product to our members.”

“The recording equipment is great for our needs,” said AAN Past President Bruce Sigsbee, MD, FAAN, who recently joined Practice Committee Chair Jonathan P. Hosey, MD, FAAN, to film an overview of new payment delivery models while in Minneapolis for a committee meeting. “The recordings are professional, communicating the key messages, be they informational, a call to action, or educational.”

Hosey concurred. “The AAN’s video capabilities add to the other sources of information for our members. We now can produce up-to-the-minute educational sessions by national experts and opinion leaders for our members’ benefit.”

The AAN began producing promotional videos in the mid-2000s, but broadcasting through AAN.com was hampered by issues with large media files and bandwidth. The arrival of YouTube and the ability to simply upload videos to the popular site eliminated the constraints of the AAN’s website, and the Academy has produced and posted more than 125 videos on the YouTube AANChannel—including popular patient education videos hosted by such celebrities as Michael J. Fox, John O’Hurley, and Teri Garr. They can be found at www.youtube.com/AANChannel.

The American Brain Foundation also has a number of videos online at www.youtube.com/CureBrainDisease. The Foundation promotes its Neuro Film Festival® and shows videos submitted for public voting at www.youtube.com/NeuroFilmFest.

Right: Practice Committee Chair Jonathan P. Hosey, MD, FAAN, (left) and AAN Past President Bruce Sigsbee, MD, FAAN, recorded a discussion of new payment delivery models for Academy members.

Right above: Staff member Andrew Lucas made adjustments on the video control board.
Social Media Increase Member, Public Connections to Academy

The AAN has embraced social media as a means to get its messages out to a wider audience of members and the public. And while the younger “millennial” generation—generally defined as those born between 1982 and 1993—have integrated Facebook pages, YouTube, and instant messaging in their professional and personal lives, confusion about what value these media offer and hesitancies about privacy and security can keep other people needlessly out of the loop. If you place yourself in the latter category, you could be missing important breaking news from sources you rely on, such as the AAN or other scientific or educational institutions.

“Neurologists often complain they suffer from information overload,” said Orly Avitzur, MD, MBA, FAAN, member of the AAN Board of Directors and chair of the Medical Economics and Management Committee. “But social media actually can help you focus on the information that is important to you, and it can alert you and deliver that information more quickly than print publications or even our website if you are not a daily visitor. And if you have a smartphone, you are better connected to your colleagues, institutions, or the AAN than anyone could have imagined a decade or two ago. Networking with colleagues or being alerted to the latest research finding or AAN CME product has never been quicker or simpler.”

Anthony G. Alessi, MD, FAAN, chair of the AAN Sports Neurology Section, agrees. “Access to the AAN through social media has allowed me to keep up with rapidly changing information and improved the efficiency of my practice.”

AAN member Jeff Kraakevik, MD, also checks his Twitter feed regularly. “I often see updates from the AAN about new research articles from the journal Neurology. I’ve been able, through Twitter, to ask questions of AAN staff members about specifics for upcoming meetings. The reply back is very timely, and has always been helpful. I’ve greatly enjoyed watching the Neuro Film Festival video contest entries as they have been really artfully and thoughtfully done.”

But Kraakevik sees missed opportunities for members who are not taking advantage of these AAN media. “At the Annual Meeting the last few years, I’ve had nice conversations with other people in the sessions I have attended about the material being presented. However, the discussion is not anywhere near as rich as I’ve seen at meetings of other specialties where there is a higher Twitter presence. In general, there is an absence of monitor changes in how information is communicated, but to foresee how these changes shape the younger generations of medical students and residents and anticipate what they will expect as they become active members of the AAN,” said Avitzur. “At the same time, we need to balance the needs of members who prefer more traditional modes of communication with the fact that rising costs for printing and postage have an impact on the AAN’s budget. Social media and smartphone applications are very attractive because of their low delivery costs as well as the speed at which information can be delivered.”

How to Get Started and Use AAN Social Media

The Academy now has more than 30 social media channels on Facebook, Twitter, YouTube, LinkedIn, Pinterest, and Google+. Altogether, nearly 100,000 people follow the AAN and its brands on social media. If you’re not yet connected, here’s what you are missing:

- **Facebook, Twitter, and Google+** provide platforms for connecting with the Academy, fellow members, colleagues, and friends. The AAN and its publications post the latest news and research in neurology as quickly as it’s available for your convenience.
- The AAN YouTube channels provide interviews, news, and updates on Academy programs in lively videos, as well as entries and winners for the American Brain Foundation’s annual Neuro Film Festival.
- Our Pinterest page provides a creative space to share interests and hobbies in everything neurology.

To quickly find these social media sites and get connected easily to the AAN, visit www.aan.com/connect, select your choice, and create a simple account. Then, to get the latest Academy news, “Like” us on Facebook, “Follow” us on Twitter, YouTube and Pinterest, and “Circle” us on Google+—it’s that easy.
Renew Your AAN Membership, Enhance Your Career—At Every Stage

Continued from cover

mandated maintenance of certification requirements. An AAN membership also gives you access to the AAN’s clinical practice guidelines, helps you develop and hone leadership skills and stay connected to your peers through exclusive year-round networking opportunities.

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IDIOPATHIC STABBING HEADACHE
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MIGRAINE WITH AURA, MIGRAINE WITHOUT AURA

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“...The most important thing is having
support, no matter what the disease is,
whether it be medical professionals or,
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In 2011, what began as a twitching in his
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18-year-old Tom. With no family history of
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as a surprise to the young man whose passion
for working on electronics—designing and
building his own computers and 3-D printers
from scratch—relied so heavily on the use of
the very “tools” most impacted: His hands.

Thanks to his neurologist, seizure medication,
and the support of his family and friends,
Tom has been able to successfully control
his epilepsy to the point where today it
has “minimal impact” on his daily life—one
that includes pursuing an electrical
engineering degree. Outside of school,
Tom enjoys camping, hiking, and
spending time with friends and family.

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Did you know?

Every 20 seconds a Traumatic Brain Injury occurs.

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Help us fund research and pave the way to a cure for brain disease.

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2014 Palatucci Advocacy Leadership Forum Participants Named

Thirty AAN members have been selected to attend the 12th Donald M. Palatucci Advocacy Leadership Forum in San Diego next month. The participants will learn about the legislative process and how to shape powerful messages to share with lawmakers and the media. The new advocates will be mentored by members who have completed the Forum in recent years. These advisors will share their experiences and insights as they coach the attendees on their advocacy action plans at the Forum and provide additional support over the coming year.

The Palatucci Advocacy Leadership Forum was developed by the AAN in 2003 to train members to be successful grassroots advocates and effective spokespeople for their patients and the neurology profession. Since then, 325 AAN members from 44 US states, the territory of Puerto Rico, and 18 countries have received this award-winning training. For more information about the Forum, visit www.aan.com/view/2014palf or contact Melissa Showers at mshowers@aan.com or (612) 928-6056.

Advocates

Syeda Laila Alqadri, MD
Rosalyn Aranas, MD
Dimitrios Arkilo, MD
Miya Asato, MD
Komal Hargorind Ashraf, DO
William S. Baek, MD
Kelly Baldwin, MD
Gurdeesh Bedi, MD
Neerali S. Bernard, DO
Nicholas Blondin, MD
Hsiong Chen, MD
Ilan Jacob Danan, MD
Justin Dominick, MD
Alan G. Finkel, MD, FAAN, FAHS
Chloe Electra Hill, MD
Neil R. Holland, MBBS, FAAN
David J. Likosky, MD, SFHM
Raman K. Malhotra, MD
Abdul Malik, MD
Paul G. Mathew, MD, FAHS
Sonia Nayyar, MD
Gaurang M. Palikh, MD
Mary Payne, MD
Eugene L. Scharf, MD
Tanzid Shams, MD
Jackson, MS
Elk Grove Village, IL
St. Paul, MN
Pittsburgh, PA
Ann Arbor, MI
Rancho Cucamonga, CA
Danville, PA
Stillwater, MN
Philadelphia, PA
Fairfield, CT
Crystal Lake, IL
White Plains, NY
Tarzana, CA
Chapel Hill, NC
Philadelphia, PA
West Long Branch, NJ
Kirkland, WA
Saint Louis, MO
Karachi, Pakistan
Boston, MA
Jamesville, NY
Shelby, NC
Huntington, WV
Rochester, MN
Roslindale, MA
Mughis Sheerani, MD
Richard M. Tresley, MD
Kolawole W. Wahab, MD
Korwyn Williams, MD, PhD
Eric Williamson, MD

Advisors

Jeffrey Bigelow, MD
Jori Fleisher, MD
James N. Goldenberg, MD
Jennifer M. Kwon, MD
Michael E. Markowski, DO
John A. Morren, MD
Nilay R. Shah, MD
Mambakkam R. Sivakumar, MD, FAAN
Waimei Amy Tai, MD
Janice F. Wiesman, MD

Faculty

Donn Dexter, MD, FAAN
Mamta Bhushan Singh, MBBS, MD, DM

Moderator

Nicholas E. Johnson, MD

Karachi, Pakistan
Chicago, IL
Ilorin, Nigeria
Phoenix, AZ
Los Angeles, CA
Murray, UT
Philadelphia, PA
Lake Worth, FL
Rochester, NY
Hyannis, MA
Cleveland, OH
Mt. Kisco, NY
Chennai, India
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New Delhi, India
Salt Lake City, UT
and funding for investigator initiated research is possible. There
Illinois. A dedicated Movement Disorders clinical trial coordinator
Movement Disorders neurologist to join the expanding Movement
Center
Maine: Neurology Position with Central Maine Medical
cadencehealth.org; (630) 933-5135; www.cadencehealth.org
For more information please contact: Melanie.harkins@
coverage for the full scope of diagnoses including movement
provides both inpatient and outpatient general pediatric neurology
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outdoor adventure found in Maine. Interested candidates,
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dental, disability coverage, retirement plans, a solid DME package,
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and is a wonderful place to live. There are over 2.5 million people in
a particular interest in stroke medicine is a plus. Enjoy being a
caregiver. UW-Madison is an Affirmative Action/Equal Opportunity Employer.
Movement Disorders Specialist – Chicago Western Suburbs
The Neurosciences Institute seeks a 3rd fellowship trained BC/BE
Movement Disorders neurologist to join the expanding Movement Disorders Center at Central DuPage Hospital (CDH) which serves the rapidly growing western suburbs of Chicago. In addition to an active clinical program, the DBS Program is one of the busiest in Illinois. A dedicated Movement Disorders clinical trial coordinator and funding for investigator initiated research is possible. There are also opportunities to pursue basic science research with our molecular neurobiologist. Patient care is foremost and enhanced by the close interdisciplinary team of specialists including neuro- psychologists, psychiatrists, social workers and other medical specialists. This is a wonderful opportunity to pursue a career in Cadence Physician Group and CDH, premier healthcare provider in the Chicago western suburbs. We offer competitive compensation and benefits and a collegial work environment within a physician led team. Cadence Health is a locally based, locally governed health system focused on delivering excellent health care to the more than 1.1 million patients in Chicago’s western suburbs. For six of the past seven years (2006-2010, 2012), Central DuPage Hospital (CDH) has been selected by Truven Health Analytics as one of the “Top 100 Hospitals in the US” CDH and Delnor maintain affiliations with Ann & Robert H. Lurie Children’s Hospital of Chicago for pediatric specialty care and Cleveland Clinic for cardiac surgery, adult medical services. Both hospitals have achieved Magnet® recognition for nursing services from the American Nurses Credentialing Center. Cadence Health employs more than 6,100 professionals providing care across an array of healthcare organizations. Both hospitals have achieved Magnet® recognition for nursing services from the American Nurses Credentialing Center. Cadence Health also includes Cadence Physician Group, a local network of more than 280 primary care physicians and specialists. For more information please contact: Melanie.harkins@ cadencehealth.org; (833) 933-5135; www.cadencehealth.org
Maine: Neurology Position with Central Maine Medical Center
MAINE: Central Maine Medical Center is seeking a BC/BE neurologist to join an established adult neurology practice. An interest or competence in stroke, muscle disease, headache/ migraine, epilepsy, or movement disorder would be a welcome addition, but are not required. A competitive salary and attractive benefits package are enhanced by the scenic beauty and abundant outdoor adventure found in Maine. Interested candidates, please send CV to Babette Irwin, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240. Fax: (207) 795-5698, email: Birwin@cmcm.org, or call: (800) 445-7431.
Child Neurology Practice Opportunity: Our Neurology Division provides both inpatient and outpatient general pediatric neurology coverage for the full scope of diagnoses including movement disorders, neuro- and neuromuscular diseases, stroke, and all other neurological emergencies and conditions. We draw patients from a 5 state region. Children’s is committed to a vision of a regional center of excellence around pediatric neurosciences. This Neuroscience Center will bring all key specialties together under one roof, all of which are staffed by a highly integrated care model. This evolving program will have a dedicated inpatient unit targeted to open in late 2013 for epilepsy, and medical/surgical neurology, with state of the art video monitoring capability. The opening of our new PCU in 2012 has also increased our ability to do inpatient monitoring, and we are in the process of expanding the neonatal neurointensive care program. Children’s has over 380 beds, including 100 NICU beds. Yearly, there are over 13,000 admissions, 22,000 surgeries, and 90,000 emergency room visits. The pediatric neurology service includes over 1,600 patients, represents all pediatric subspecialties. Professional and Personal Rewards: Compensation/ Benefits we offer a lucrative compensation package including a base pay with incentive pay opportunities. Our comprehensive benefits package includes malpractice, health, dental, disability coverage, retirement plans, a solid DME package, PFO/CME time, and much more. Community: The Twin Cities consistently rank as one of the top ten most liveable cities in the US and is a wonderful place to live. There are over 2.5 million people in a particular interest in stroke medicine is a plus. Enjoy being a hospital employee with a comprehensive benefit package and call of 1.3. Competitive salary with productivity incentive, sign-on and loan repayment. Significant loan repayment potential through the Doctors Across New York program of $150,000. Big hospital, small city. Medical city. For more information please contact: Brian Malecki, M.D., Catamount Medical Group, 100 Olympic-Lake Placid region, Burlington, VT, and Montreal. For more information please log on to www.northerncountrygyd.com or contact Rebecca Larkin (jlarkin@cvmh.org) 7 Beeke St., Plattburgh, New York 12901, (518) 564-3272, Fax: (518) 562-7012.
Neurologists NYC Medical Center, looking to expand its service network, seeks General Neurologists and Neurologist with Stroke Certification to join a team of two other Neurologists. Duties include providing services to an acute hospital with an award winning designated Stroke Unit, and an active consult service, along with a hospital based private practice in General Neurology. Positions require a NYS license, BC/BE in Neurology, and completion of a Neurology Residency program. We offer a competitive salary and benefit package, along with a convenient location near JFK Airport. Email: acareyck@nycmc.org
Neurology Opportunity in the Greater St. Louis, MO Area
Memorial Medical Group (MMG) is a multi-specialty group, located in Belleville, IL which is 15 minutes from downtown St. Louis. MMG is looking for a Neurologist to join two other physicians in a very busy physician practice. MMG offers: an outstanding compensation package, 16,000 sign-on bonus/up to $10,000 in relocation assistance, benefits to include health, dental, life, money purchase plan and CME, flexible schedule, the ability for physician to customize their own practice, great communication between referring physicians. Requirements BC/BE, US citizen/permanent resident. By joining MMG, you will manage your practice on a daily basis, yet be able to call upon MMG administrative staff when necessary for health resource, financial or operations support, have access to more technology, centralized billing and insurance procedures, gain marketing support, patient communications tools and a full network of primary care physicians. If interested, please contact: Stephanie Walter—Physician Recruiter, Office: (618) 257-8754, Cell: (618) 420-5524. Email: swalter@memhosp.com
Neurology Opportunity in the Metro St. Louis Area offering $36,000 Sign on Bonus Eligible for BC/BE Neurologist to join our employed physician group. The practice has two other Neurologists. The position offers: compensation package including base salary with potential for bonus, $36,000 sign-on bonus and relocation assistance available, well-established practice. A large primary care provider base within the group that will serve as part of your referring physicians. If interested, please contact: Stephanie Walter—Physician Recruiter, Office: (618) 257-8754, C. (618) 420-5524. Email: swalter@memhosp.com
Neurologist/Neurohospitalist A large, academically oriented subspecialists and general neurologist. We are a multidisciplinary neurology practice. We are affiliated with three major teaching hospitals. An academic appointment will be obtained and some resident and/or medical student teaching is required. While a subspecialty interest is not an absolute requirement, it is not a necessity. We currently have neurologists with subspecialty areas in Stroke, Multiple Sclerosis, Parkinson’s and Neuromuscular Disease. Our office performs all ambulatory diagnostic testing. We seek a hardworking, well-trained person interested in clinical practice to join us. Please email resumes to cvp@memhosp.com.
Neurologist Exceptional opportunity for hardworking, motivated general and/or subspecialty-trained neurologist(s) to join a busy, well-respected adult private neurology practice. Our practice includes seven offices and a sleep lab in suburban Maryland and Washington, DC. The practice size and geographic range served allow us to foster the development of subspeciality practices, so those with such expertise are enthusiastically sought. An excellent salary, benefit package and early partnership are available. Please send CV and letter of interest to: The Neurology Centers of PA, c/o Ezra D. Cohen, MD, 1201 Seven Locks Road, Suite 101 Rockville, MD 20854 or via email to recruiting@neurocenter.com. Please visit our website at www.neurocenter.com
Neurologists Well-established, quality oriented neuroscience group seeks to add additional neurologists. Opportunity for subspecialty fellowship and academic appointment. We are a multidisciplinary neuroscience group providing a strong team oriented environment and opportunities for professional growth. Our location offers easy access to the cultural institutions of Boston, the mountains, the ocean, as well as outstanding private and public school opportunities for children. Send CV to Howard M. Gardner, MD, Medical Director, New England Neurological Associates, P.C., RIVERSWALK, 354 Merrimack Street, Lawrence, MA 01843, or email to jfh@neuro.com. Visit us on the web at www.neuro.com
North Shore Region Dozehner Health System North Shore is seeking BC/BE General Neurologists, as well as neurologists with subspecialty training. Both newly trained and experienced neurologists are encouraged to apply. The Department of Neurology has a complement of 24 neurologists system-wide with subspecialty representation in stroke, neurocritical care, interventional neurology, neuromuscular disease, movement disorders, epilepsy, MS, headaches, cognitive disorders and sleep. We are a Top 5 Neuroscience Center in the latest US News and World Report rankings. The telemedicine stroke program at Dozehner Medical Center is one of the most advanced in the nation. Dozehner Medical Center is a 200 bed tertiary care center on Jefferson Highway in New Orleans. In addition, the North Shore will have the availability of neuro-subspecialists in movement disorders and epilepsy on a regular basis. Octner North Shore has over 150 physicians and mid-level providers with twelve locations in six communities providing an excellent referral base. Dozehner Health System is a physician-led, academic, multi-specialty, non-profit healthcare delivery system. We employ over 900 physicians, and our system includes 9 hospitals and more than 40 health centers. We also enjoy the advantage of practicing in a favorable malpractice environment in Louisiana. Please visit our website, www.ohnortheast.com for more information. The North Shore is located across Lake Pontchartrain from New Orleans. These beautiful suburbs offer sophisticated living in a family-oriented environment. This area provides numerous cultural, historical,
In-house ad

Oligohydrosis resulting in hospitalization has been

CONTRAINDICATIONS

IMPORTANT SAFETY INFORMATION

capsules for oral use

Trokendi XR has now been available in your area. For more information, visit www.TrokendiXR.com.

The first and only once-daily extended-release formulation of topiramate utilizing Microtrol® technology

Trokendi XR is now available in your area. For more information, visit www.TrokendiXR.com.

Trokendi XR (topiramate) extended-release capsules for oral use

INDICATION

• Trokendi XR is indicated as initial monotherapy in patients 10 years of age and older with partial or primary, generalized tonic-clonic seizures and adjunctive therapy in patients 6 years of age and older with partial onset or primary, generalized tonic-clonic seizures. Safety and effectiveness in patients who were converted to monotherapy from a previous regimen of other anticonvulsant drugs have not been established in controlled trials.

• Trokendi XR is indicated as adjunctive therapy in patients 6 years of age and older with seizures associated with Lennox-Gastaut syndrome.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

• Trokendi XR is contraindicated in patients with recent alcohol use (within 6 hours prior to and 6 hours after Trokendi XR use), and also in patients with metabolic acidosis who are taking concomitant metformin.

WARNINGS & PRECAUTIONS

• A syndrome consisting of acute myopia associated with secondary angle closure glaucoma has been reported in patients receiving topiramate. Symptoms can include acute onset of decreased visual acuity and/or ocular pain, myopia, anterior chamber shallowing, ocular hyperemia, and increased intraocular pressure. Symptoms typically occur within 1 month of initiating topiramate therapy. The primary treatment to reverse symptoms is discontinuation of Trokendi XR as rapidly as possible. Elevated intraocular pressure of any etiology, if left untreated, can lead to serious sequelae including permanent vision loss.

• Oligohydrosis resulting in hospitalization has been reported in some cases in association with topiramate use. The majority of reports have been in pediatric patients. Patients, especially pediatric patients, should be monitored closely for evidence of decreased sweating and increased body temperature, especially in hot weather. Caution should be used when Trokendi XR is prescribed with other drugs that predispose patients to heat-related disorders.

• Hyperchloremic, non-anion gap, and metabolic acidosis has been reported in adults and pediatric patients treated with topiramate. This metabolic acidosis is caused by renal bicarbonate loss due to the inhibitory effect of topiramate on carbonic anhydrase. Conditions that predispose patients to acidosis may be additive to the bicarbonate lowering effects of topiramate. Although Trokendi XR is not approved for children under 6 years of age, a study of topiramate as adjunctive treatment in patients under 2 produced metabolic acidosis of a notably greater magnitude than in older children and adults. Measurement of baseline and periodic serum bicarbonate during topiramate treatment is recommended. If metabolic acidosis develops and persists, consideration should be given to reducing the dose or discontinuing topiramate.

• In vitro data show that, in the presence of alcohol, the pattern of topiramate release from Trokendi XR capsules is significantly altered. Alcohol use should be completely avoided within 6 hours prior to and 6 hours after Trokendi XR administration.

• Antiepileptic drugs (AEDs) increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED, including Trokendi XR for any indication, should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior. Anyone prescribing Trokendi XR must balance the risk of suicidal thoughts or behavior with the risk of untreated illness. Epilepsy and many other illnesses for which antiepileptic drugs are prescribed are themselves associated with morbidity and mortality and an increased risk of suicidal thoughts and behavior. Should suicidal thoughts and behavior emerge during Trokendi XR treatment, the prescriber needs to consider whether the emergence of these symptoms in any given patient may be related to the illness being treated.

• Patients, their caregivers, and families should be informed that AEDs increase the risk of suicidal thoughts and behavior and should be advised of the need to be alert for the emergence or worsening of the signs and symptoms of depression, any unusual changes in mood or behavior or the emergence of suicidal thoughts, behavior, or thoughts about self-harm. Behaviors of concern should be reported immediately to healthcare providers.

• Adverse reactions most often associated with use of topiramate, and therefore expected to be associated with the use of Trokendi XR, were related to the central nervous system (CNS) and were observed in the epilepsy population. In adults, the most frequent of these can be classified into three general categories: cognitive-related dysfunction, psychiatric/behavioral disturbances, and somnolence or fatigue. Additional nonspecific CNS events observed with topiramate in the adjunctive epilepsy population include dizziness or ataxia. In double-blind adjunctive and monotherapy epilepsy clinical studies conducted with topiramate, the incidence of cognitive/neuropsychiatric adverse reactions in pediatric patients were generally lower than observed in adults.

• Topiramate can cause fetal harm when administered to a pregnant woman. Use during pregnancy and data from pregnancy registries indicate that infants exposed to topiramate in utero can have increased risk of cleft lip and/or cleft palate. Trokendi XR should only be used during pregnancy if the potential benefit outweighs the potential risk. Patients should be informed of the potential hazard to the fetus.

• Antiepileptic drugs, including Trokendi XR, should be gradually withdrawn to minimize the potential for seizures or increased seizure frequency.

• Hypermannemonia with and without encephalopathy has been observed in post-marketing reports in patients who were taking topiramate with or without concomitant valproic acid (VPA). Hypermannemonia appears more common when used concomitantly with VPA. Although Trokendi XR is not indicated for use in infants or toddlers, topiramate with concomitant VPA produced a dose-related increase in hypermannemonia in this population.
**NEW ONCE-DAILY**

**Trokendi XR**
(extende**nd release capsules)

25 mg  50 mg  100 mg  200 mg

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- The concomitant use of Trokendi XR with any other drug producing metabolic acidosis, or potentially in patients on a ketogenic diet, may increase the risk of kidney stone formation, and should therefore be avoided.

- Hypothermia has been reported in association with topiramate use with concomitant valproic acid (VPA) both in the presence and in the absence of hyperammonemia. Consideration should be given to stopping topiramate or valproate in patients who develop hypothermia; clinical management should include examination of blood ammonia levels.

- Paresthesia, an effect associated with the use of other carbonic anhydrase inhibitors, appears to be a common effect of topiramate, and was more frequently reported in monotherapy epilepsy trials with topiramate than adjunctive therapy epilepsy trials.

- Topiramate is a CNS depressant. Concomitant administration of topiramate with other CNS depressant drugs can result in significant CNS depression. Patients should be watched carefully when Trokendi XR is coadministered with other CNS depressant drugs.

### DOSSING GUIDELINES & CONSIDERATIONS

- Refer to the Trokendi XR - DOSAGE AND ADMINISTRATION section of the full prescribing information for recommended dosing guidelines for Trokendi XR monotherapy and adjunctive therapy use.

- In patients with renal impairment (creatinine clearance less than 70 mL/min/1.73 m²), one-half of the usual adult dose is recommended. Such patients will require a longer time to reach steady-state at each dose.

- In patients undergoing hemodialysis, to avoid rapid drops in topiramate plasma concentration, a supplemental dose of topiramate may be required. The actual adjustment should take into account the duration of dialysis period, clearance rate of the dialysis system being used, and the effective renal clearance of topiramate in the patient being dialyzed.

- Addition or withdrawal of phenytoin and/or carbamazepine during adjunctive therapy with Trokendi XR may require adjustment of the dose of Trokendi XR.

- Trokendi XR can be taken without regard to meals. Swallow capsule whole and intact. Do not sprinkle on food, chew, or crush.

### ADVERSE REACTIONS

- Trokendi XR has not been studied in a randomized, placebo-controlled phase 3 clinical study in the epilepsy patient population; however, it is expected that Trokendi XR would produce a similar adverse reaction profile as that of immediate-release topiramate. See the ADVERSE REACTIONS section of the Trokendi XR full prescribing information for further adverse reaction rates from the clinical trials conducted under widely varying conditions.

- In adjunctive therapy trials, the most common adverse reactions of topiramate at dosages of 200 to 400 mg/day in adults that did not appear to be dose-related were somnolence (29% v 12%), 200 to 400 mg/day v placebo, respectively, ataxia (16% v 7%), speech disorders-related speech problems (13% v 2%), psychomotor slowing (13% v 2%), vision abnormal (13% v 2%), difficulty with memory (12% v 3%), paresthesia (11% v 4%), and diplopia (10% v 5%). The most common dose-related adverse reactions at dosages of 400 mg/day in adults with partial onset seizures were fatigue (12% v 3%), topiramate v placebo, respectively, nervousness (18% v 7%), difficulty with concentration/attention (9% v 1%), confusion (10% v 4%), depression (7% v 6%), anorexia (6% v 4%), language problems (3% v <1%), anxiety (3% v 6%), mood problems (6% v 2%), and weight decrease (5% v 3%). The most common adverse reactions at dosages of 5 mg/kg/day to 9 mg/kg/day in pediatric patients were fatigue (16% v 5%).

**Please refer to the full Prescribing Information for Trokendi XR.**

**Please see the Brief Summary for Trokendi XR on the adjacent page.**

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**References:**

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**Supernus Pharmaceuticals**

Trokendi XR is a trademark and Microtrol® is a registered trademark of Supernus Pharmaceuticals, Inc.

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Acute Myopia and Secondary Angle Closure Glaucoma

Secondary angle closure glaucoma associated with topiramate has been reported rarely. Initiate therapy at 25 mg to 50 mg once daily with gradual titration to a potentially effective dose in weeks 1 and 2. Daily topiramate doses of 25 mg to 50 mg once daily followed by titration to an effective dose in increments of 25 mg to 50 mg every week are recommended. Initiate therapy at 25 mg to 50 mg once daily and titrate to an effective dose. The proportion of patients who experienced one or more cognitive-related adverse reactions was 19% for 50 mg per day and 26% for 400 mg per day. Psychiatric/Behavioral Disturbances - Psychiatric/behavioral disturbances such as mood/behavior changes, depression, anxiety, irritability, aggression, aggression with physical injury, and anger have been observed in patients on topiramate. Safety and effectiveness in patients who were converted to monotherapy from a previous regimen of other anticonvulsant drugs have not been established in controlled trials.

Bicarbonate decrements are usually mild-moderate (average decrease of 4 mEq/L at baseline) and taper to normal levels over weeks to months of treatment. Decreases in serum bicarbonate have been observed in patients maintained on topiramate for long periods of time. Electrolyte imbalance has been observed in post-marketing reports of patients taking topiramate. Such electrolyte imbalance may include hypochloremia, hypokalemia, hyperglycemia, and alkalosis. Hypochloremia, hypokalemia, and hyperglycemia are known to cause metabolic acidosis. Tonic-clonic seizures. Safety and effectiveness in patients who were converted to monotherapy from a previous regimen of other anticonvulsant drugs have not been established in controlled trials. In controlled trials conducted with immediate-release topiramate, the incidence of alanine aminotransferase (ALT) and aspartate aminotransferase (AST) levels more than 3 times the upper limit of normal was 0% for placebo, 7% for 5 mg/kg/day, 10% for 15 mg/kg/day, 15% for 30 mg/kg/day, and 25% for 40 mg/kg/day.

Trokendi XR™ (topiramate) extended-release capsules are indicated as adjunctive therapy in patients 6 years of age and older with partial onset seizures or Lennox-Gastaut Syndrome. To assess for the development of persistent metabolic acidosis during long-term topiramate therapy, the serum bicarbonate levels of patients treated with topiramate should be periodically monitored. Initial metabolic acidosis is more likely to occur in children treated with topiramate, although these patients with epilepsy are likely to have different growth rates than normal infants. Reductions in Z SCORES for height and weight were correlated to the degree of acidosis. Topiramate treatment that causes metabolic acidosis (defined by a serum bicarbonate less than 20 mEq/L) was 0% for placebo, 30% for 5 mg/kg/day, 50% for 15 mg/kg/day, and 50% for 25 mg/kg/day. Metabolic acidosis may include hyperchloremic, non- ketoacidotic metabolic acidosis (H型), and hyperglycemic, nonketotic metabolic acidosis (H型). Accordingly, a prolonged period of diazepam may cause topiramate concentration to fall below that required to maintain treatment effectiveness in controlled trials conducted to monitor plasma levels of topiramate in patients with partial seizures. Therefore, the serum bicarbonate during Trokendi XR™ treatment is recommended. If metabolic acidosis develops and persists, consideration should be given to reducing the dose of topiramate or discontinuing therapy. Patients with diabetes mellitus, hypothyroidism, or autonomic dysfunction should be monitored closely. Patients on topiramate in the face of persistent acidosis, alkali treatment should be considered.

Trokendi XR™ (topiramate) extended-release capsules are indicated as adjunctive therapy in patients 6 years of age and older with partial onset seizures or Lennox-Gastaut Syndrome. Such electrolyte imbalance has been observed with the use of topiramate in placebo-controlled clinical trials and in the adjunctive epilepsy double-blind studies conducted with topiramate. Incidences of serum bicarbonate levels less than 20 mEq/L (indicative of metabolic acidosis) in patients treated with immediate-release topiramate in controlled trials were 0% for placebo, 30% for 5 mg/kg/day, 50% for 15 mg/kg/day, and 50% for 25 mg/kg/day. The proportion of patients who experienced one or more cognitive-related adverse reactions was 19% for 50 mg per day and 26% for 400 mg per day. Psychiatric/Behavioral Disturbances - Psychiatric/behavioral disturbances such as mood/behavior changes, depression, anxiety, irritability, aggression, aggression with physical injury, and anger have been observed in patients on topiramate. Safety and effectiveness in patients who were converted to monotherapy from a previous regimen of other anticonvulsant drugs have not been established in controlled trials.
After increasing the daily dose of topiramate. Consideration should be given to stopping topiramate or valproate in patients
with encephalopathy (without and with concomitant valproic acid use; kidney stones; hypothermia with concomitant valproic
acid use). Topiramate is associated with an increased risk of lactic acidosis and hepatic failure (including fatalities) and should be
monitored for the appearance or worsening of metabolic acidosis when Trokendi XR™ is given concomitantly with
anhydrase inhibitor, with any other carbonic anhydrase inhibitor (e.g., zonisamide, acetazolamide or dichlorphenamide),
oral sulfonylurea, salicylate, aspirin, warfarin, or any protease inhibitor. The incidence of metabolic acidosis is increased in
children and adolescents treated with immediate-release topiramate. Topiramate is associated with an increased risk of
seizures, particularly simple (myoclonic, absence) seizures, and status epilepticus when used concomitantly with
enzyme-inducing oral antiepileptic drugs (OATs). The use of enzyme-inducing OATs increases the rate of clearance of
immediate-release topiramate and decreases plasma concentrations of topiramate. Concomitant administration of
valproic acid and topiramate is associated with an increased risk of lactic acidosis and hepatic failure (including fatalities)
without and with concomitant valproic acid use. In addition, topiramate increases the risk of renal stones.

**USE IN SPECIFIC POPULATIONS**

**Pregnancy Category B** - Topiramate can cause fetal harm when administered to a pregnant woman. Data from
pregnancy registry studies indicate that infants exposed to topiramate in utero have increased risk for cleft lip and/or cleft
palate, cleft lip with or without cleft palate, anorectal malformations, or other congenital malformations. The risk
cannot be estimated with certainty. This risk appears to increase when the mother is exposed to topiramate during the
first trimester of pregnancy. When oral doses of 20 mg/kg or greater were administered to pregnant mice, an incidence of
oral clefts of 0.2% among infants exposed to topiramate monotherapy. The observed rate of oral clefts was 16 times higher
than the background incidence in the control group. The incidence of oral clefts was 1.5 times higher among infants exposed
to topiramate in utero as compared to infants of mothers not exposed to or at a rate higher than in the 0.1% that was
observed after increasing the daily dose of topiramate. The effect of topiramate-induced metabolic acidosis has not been
studied in pregnancy. However, metabolic acidosis in pregnancy due to concomitant use of topiramate should be
monitored for the appearance or worsening of metabolic acidosis. The incidence of renal stones is increased in patients
exposed to topiramate in utero. Renal stones have also been reported after polydrug overuse involving topiramate.
Topiramate overdose has resulted in severe metabolic acidosis. The risk of metabolic acidosis due to topiramate
overdose is increased when there is an increased risk of lactic acidosis in patients with impaired renal function and
limited exposure in patients with impaired renal function. Topiramate overdose has resulted in several deaths, with the
risk of lactic acidosis in patients with impaired renal function and limited exposure in patients with impaired renal
function. Topiramate overdose has resulted in seizures that may cause topiramate concentration to fall below that required
to maintain an anti-seizure effect. To avoid rapid drops in plasma concentrations, topiramate should be avoided during
the period of organogenesis, the incidence of fetal malformations (primarily craniofacial defects) was increased at
clinically relevant doses. When oral doses of 20 mg/kg, 100 mg/kg, or 500 mg/kg were administered to pregnant mice
(incidence greater than or equal to 5%) and at a rate higher than in the nonpregnant state. Newborns of mothers treated with
topiramate should be monitored for metabolic acidosis because of the increased risk of renal stones. The data
indicating the increased risk of oral clefts were derived from observational studies of topiramate exposure in utero. The
human data regarding the incidence of oral clefts in infants exposed to topiramate monotherapy are insufficient to
determine whether topiramate causes structural anomalies of the mouth and face. The prevalence of oral clefts was
1.2% compared to a prevalence of 0.39% - 0.46% in infants exposed to other AEDs. The observational studies of the
Registry indicate an increased risk of oral clefts in infants exposed to topiramate monotherapy during the first trimester of
pregnancy. Because the Registry did not include, at the time of its preparation, data regarding the risk of oral clefts in
infants exposed to topiramate monotherapy in the second and third trimesters of pregnancy, the Registry does not
provide any data on the risk of clefts in infants exposed to topiramate in the second and third trimesters of pregnancy.

**ALCOHOL** - Alcohol use is contraindicated within 6 hours prior to or 6 hours after Trokendi XR™ administration.
**Oral Contraceptives** - Exposure to fertility effects or estradiol was statistically significantly increased when topiramate doses
above 200 mg/day were given as adjunctive therapy in patients taking valproic acid. However, no effect on fertility or
infertility was not significantly affected. In another pharmacokinetic interaction study in healthy volunteers with a
concomitantly administered oral contraceptive, no clinically significant changes in plasma concentrations of
ethinyl estradiol and progestins were observed. Therefore, use of oral contraceptives is not recommended. Use of oral
contraceptives should be considered in patients taking Trokendi XR™. The risk of contraceptive failure is not known.

**CONTRAINDICATIONS**

- Hypersensitivity to topiramate or any component of Trokendi XR™. Topiramate is not recommended for use near
the site of neurosurgical procedures or for the treatment of increased intracranial pressure associated with
intracranial tumors. However, patients with hypertension (with and without hypertension) in patients with
fetuses or the effect on the fetus, the fetus, which occurs in the first trimester of pregnancy before many women know
they are pregnant. All women of childbearing potential should be asked if they are pregnant or if the patient becomes pregnant while taking this drug. The patient should be informed of the possible hazard to the fetus.

**Regulatory Status**

- Women of Childbearing Potential - Topiramate should be avoided during pregnancy. Data from pregnancy registry
studies indicate that infants exposed to topiramate in utero have increased risk for cleft lip and/or cleft palate, cleft lip
with or without cleft palate, anorectal malformations, or other congenital malformations. The risk cannot be estimated
with certainty. This risk appears to increase when the mother is exposed to topiramate during the first trimester of pregnancy.

**ADVERSE REACTIONS**

**Adverse Reactions**

The following adverse reactions are discussed in more detail in other sections of the labeling: Acute Myopia and Secondary Angle-Closure Glaucoma; Hepatotoxicity; and Withdrawal of Antiepileptic Drugs: Hyperammonemia and Encephalopathy (Without and With Concomitant Valproic Acid Use; Renal Stones; Hypothermia with Concomitant Valproic Acid Use). Adverse reactions that occurred in at least 1% of patients treated with Trokendi XR™ (based on controlled clinical trials) are listed below. Table 5 describes the most frequent adverse reactions that occurred in at least 1% of patients treated with Trokendi XR™ (based on controlled clinical trials) and are not included in Table 6 because the reactions are not of significant clinical importance. Table 5 describes the most frequent adverse reactions that occurred in at least 1% of patients treated with Trokendi XR™ (based on controlled clinical trials) and are not included in Table 6 because the reactions are not of significant clinical importance. Table 5 describes the most frequent adverse reactions that occurred in at least 1% of patients treated with Trokendi XR™ (based on controlled clinical trials) and are not included in Table 6 because the reactions are not of significant clinical importance. Table 5 describes the most frequent adverse reactions that occurred in at least 1% of patients treated with Trokendi XR™ (based on controlled clinical trials) and are not included in Table 6 because the reactions are not of significant clinical importance.
and recreational activities and has been ranked as one of the fastest growing cities in the United States. Please email CV to: profrecruiting@ochsner.org. Call (800) 488-2240. Ref # ANENSRR2. EOE.

Neurologists New York Hospital Queens (NYHQ). New York Hospital Queens’s Division of Neurology and Neuroscience Center seeks neurologists for its expanding stroke and epilepsy programs. NYHQ is a hospital in a teaching environment in New York City with Level 1 Trauma Center designation, outstanding quality performance scores and high levels of patient satisfaction. NYHQ, located in Flushing, is the largest hospital in Queens and serves patients within a 15-mile radius. NYHQ is also a major teaching affiliate of Weill Cornell Medical College and a member of the New York Presbyterian Healthcare System. NYHQ’s Neurology Division is one of the busiest in the region, with over 1,800 discharges in 2012. Our primary Stroke Center is the most productive in the region, serving as the largest and most intensive stroke center. Our epilepsy program is a well-established expanding program with inpatient, outpatient, ICU, and OR services. This is an outstanding opportunity for ambitious neurologists to advance in a region to become the region’s stellar institution for stroke and epilepsy clinical care, research and education. Successful candidates will be Board Certified in Neurology, qualified for WCMC faculty appointment at the Assistant/Associate Professor level, and possess strong clinical, communication and leadership skills. Interested applicants should submit a CV and letter of interest to: Calliope Evodos, Administrative Director, New York Hospital Queens, 56-45 Main Street, Flushing, NY 11355. Email can be sent to: neurology@wcm.hcp.cuny.edu.

Regional Parkinson Center in Wisconsin Seeks Movement Disorders Specialist The Regional Parkinson Center is seeking a fellowship trained Movement Disorders Specialist to join its team of board-certified neurologist, Nurse Practitioner, Neuropsychologist, nurses and researchers who see patients through the Wisconsin Institute for Neurological Studies (WINISI). More than 20,000 people with Parkinson symptoms have been treated at the Outpatient Center over the last 30 years, and the Center follows the progression of 3,000 patients annually. The Center’s standing as a leader in the treatment of Parkinson’s disease includes an enormous database that can contribute to solving treatment issues, understanding the potential causes of Parkinson’s disease. As a leader in major pharmaceutical research, the Center actively participates in drug trials that help improve the management of the disease. Located at Aurora Sinai Medical Center in downtown Milwaukee, WI, the Regional Parkinson Center has full access to inpatient and rehabilitation services with a team trained in Parkinson’s care and treatment. The Regional Parkinson Center provides comprehensive care and treatment for people with Parkinson disease and other movement disorders. The Center includes a statewide education and outreach program and world-class Parkinson Research Institute conducting studies to determine the causes of Parkinson’s disease. The Center has one of the highest Parkinson’s prevalence rates in the country. On the western shore of Lake Michigan, Milwaukee has a metropolitan population of over one million people. The city is best known for ethnic German and Polish food, inclusion of the world’s largest inland festival, Summerfest, fine restaurants, and warm friendly people. Wisconsin is home to the Milwaukee Bucks, Milwaukee Brewers, and Green Bay Packers. Email: nauisedam@parkincemt.com

Opportunity to Build Neurology Service—Home of University CA Merced Telenurereology in place. Dignity Health Medical Group—Mercy, a service of Dignity Health Medical Foundation, has an exciting opportunity for a Neurologist who is interested in building a Neurology service within the group. We are affiliated with Mercy Medical Center in Merced, CA (mercymercedcares.org/index.htm). Practice highlights include: opportunity to build Neurology service within the medical group, Telenurereology in place with Affiliate Group, Joint Commission Certified Primary Stroke Center, no mandatory hospital call, clinic building located next to our new 188-bed hospital, Medical Foundation, Dignity Health Medical Group-Mercy. Dignity Health Medical Group-Mercy is a service of Dignity Health Medical Foundation. Dignity Health Medical Foundation is affiliated with Dignity Health, one of the leading healthcare systems in the country. Merced is located in the San Joaquin Valley of California campus which is planning for the development of a medical school. Merced’s ideal setting offers close proximity to all the amenities of large metropolitan areas and the low cost, low stress environment of a family-oriented Central CA community. A short two-hour drive will lead you to San Francisco, Monterey or Sacramento, while a bit further away are Yosemite and Tahoe. The city boasts its own orchestra and theatre company and is host to a variety of festivals and other events, including a 18-hole golf courses and more than 12 miles of class-one, grade-separated bike paths. Please contact/send CV to: Lori Hart, Physician Recruiter; providers@dignityhealth.org; phone: (888) 589 7787; www.dignityhealth.org.

Help Build a Gateway for Better Health At Northwest Permanente, P.C., we invite you to consider these opportunities with our physician-managed, multi-specialty group of over 485,000 members throughout Oregon and Southwest Washington. BC Neurologists, Portland, Oregon: We’re seeking a board certified Neurologist with fellowship-level training in stroke or movement disorders. Clinical experience is required, but fellowship subspecialty training may be considered for the right individual. The candidate will have both general neurology and inpatient hospital responsibilities, as well as provide expertise in their subspecialty. Flexibility and interest in helping to pioneer new ways of providing the right neurological care for the right person will be an essential feature of this position. The qualified candidate will join 10 Neurologists in a busy, collegial and stimulating practice. Join us in the beautiful Pacific Northwest. We offer a competitive salary and benefit package which includes a generous retirement plan, significant health coverage and more. Physicians are also eligible for Senior Physician and Shareholder standing after approximately three years with the group (must be Board Certified by that time). To submit your CV and letter of interest please visit our website at: http://physiciancareers.kp.org/me and click on Physician Career Opportunities. Or call (800) 813-3762 for more information. We are an equal opportunity employer and value diversity within our organization.

Clinical Research Fellowships July 1st, 2014: Two positions are offered for a one-year fellowship in muscular dystrophy research, with option of a second year, by the Senator Paul B. Wellstone Muscular Dystrophy Cooperative Research Center. Activities will include course work in the design and implementation of clinical trials, participation in the recruitment of patients and clinical evaluation of patients with muscle diseases. One fellow will be recruited to the Center for Genetic Muscle Disorders, Kennedy Krieger Institute and the Department of Neurology, Johns Hopkins School of Medicine, in Baltimore, MD and the second fellow to the Department of Neurology, University of Massachusetts Medical School in Worcester, MA. Potential candidates should have completed a medical residency in the United States in the fields of neurology, pediatrics or PM&R. Please send cover letter and CV to Kathryn Wagner, MD, PhD at wagnerkt@kennedykrieger.org and to Johnnny Salameh, MD at Johnny.salameh@u_massmemorial.healthcare

Neurologist Seeking a BC/BE Neurologist to join our growing and successful private practice with five locations throughout Southern California. We are a multi-specialty group with general orthopedic pain management. Ideal candidate will have a strong interest in general neurology services and in practicing in an outpatient-focused, multi-specialty group. We believe that patients benefit from a comprehensive approach to their care. Our focus is on delivering optimal care by guiding our patients through the process of diagnosis, treatment, and recovery. Applicant must possess an MD degree from an accredited medical school, and be eligible to obtain a California medical license. Very generous incentive and bonus package offered. Email: tji@naepinorthcentral.com

Assistant Professor The Department of Neurology at the University of Texas Medical Branch (UTMB) at Galveston, Texas, seeks three Neurologists to grow with an expanding clinical practice and fellowship program. The ideal candidate will implement and enhance a comprehensive Movement Disorders Program at UTMB, be involved in the instruction of residents and medical students and be interested in participating in clinical research studies. Interested candidates should submit their CV to: Anish Bhardwaj, MD, MBA, FANA, FAN, John Sealy Chairman and Professor; Assistant Dean for Faculty Affairs; Director of Neurology; University of Texas Medical Branch, 9.128 John Sealy Annex, 9059, 301 University Blvd., Galveston, TX 77555-0539; anbhardw@utmb.edu

Movement Disorders Specialist The Department of Neurology at the University of Texas Medical Branch (UTMB) at Galveston, Texas, seeks a Movement Disorders specialist at the Assistant Professor level (tenure track) to be part of a well-established Neurology Department. The ideal candidate should have an MD or equivalent and be Board Certified in Neurology and fellowship trained in Movement Disorders. The ideal candidate will implement and enhance a comprehensive Movement Disorders Program at UTMB, be involved in the instruction of residents and medical students and participate in clinical research studies. The University of Texas Medical Branch at Galveston is an equal opportunity, affirmative action institution which proudly values diversity. Candidates of all backgrounds are encouraged to apply. Interested candidates should submit their CV to: Anish Bhardwaj, MD, MBA, FANA, FAN, John Sealy Chairman and Professor; Assistant Dean for Faculty Affairs; Director of Neurology; University of Texas Medical Branch, 9.128 John Sealy Annex, 301 University Blvd., Galveston, TX 77555-0539; anbhardw@utmb.edu.

Headache Medicine Neurologist The University of Toledo, Department of Neurology, seeks a BC/BE Headache Medicine Neurologist with special interest in Headache, preferably fellowship trained. The new faculty member will provide the full range of inpatient and outpatient care to patients with headache and direct the University Headache Treatment and Research Center. They will participate in resident and medical student education and have the opportunity to participate in clinical and translational research. Salary and academic rank are commensurate with qualifications. Interested applicants should send curriculum vitae and the names and addresses of three (3) references to: Grotchen Tietjen, MD Professor and Chair, Department of Neurology, 3000 Arlington Ave MS 1195 Toledo, Ohio 43614. Phone: (419) 383-3544, Fax: (419) 383.5439. Email: mntietjen@utoledo.edu. Application review will begin immediately.

Neurocritical Care Specialist The University of Toledo College of Medicine, in collaboration with Promedica Toledo Hospital, seeks three neurocritical care specialists to grow with an expanding clinical practice committed to advancing patient care, education and research. The neurocritical care specialists will join a collegial group of core faculty with subspecialty representation in epilepsy, movement disorders, stroke, migraine, neuromuscular disease, and neurointerventional care. This active service includes vascular neurologists, Neuro interventionalists, vascular fellows through an ACGME accredited vascular medicine program, cardiologists, neurology residents, medical students, and dedicated advanced practice providers support. UTMC and ProMedica Toledo Hospital are Joint Commission certified Primary Stroke Centers. This program includes 2 regional hospitals, as well as a telemedicine network. The new faculty members will provide the full range of inpatient and outpatient care to patients and will participate in
neurovascular fellow, resident and medical student education; participation in clinical and translational research is encouraged. Minimum Qualifications include MD/DO, completion of an accredited Neurology residency program, BC in Neurology or BE with completion of fellowship from an accredited US program, Ohio medical license or eligible for licensure in Ohio, Complete Neurocritical care (NCC) fellowship from an accredited program. Interested applicants should send curriculum vitae and the names and addresses of three (3) references to: Gretchen Tietjen, MD Professor and Chair, Department of Neurology, 3000 Arlington Ave MS 1195 Toledo, Ohio 43614. Phone: (419) 383-3544, Fax: (419) 383-3093. Email: ann.murphy@utoledo.edu

Neuro-Hospitalist Opportunity – Virginia Mason in Seattle
Virginia Mason Medical Center in Seattle, Washington is recruiting a BE/BC Neurohospitalist to join a rapidly growing inpatient team dedicated to serving the needs of patients with acute neurological disease. Our ideal candidate will have a passion for excellence in acute stroke care and will be integral to the participation in clinical research is encouraged. Strong clinical and interpersonal skills and involvement in process improvement work are required. Virginia Mason Hospital has been a TJC accredited primary stroke center since 2004. The VM Stroke Center received the Stand up for Patient Safety Award from the National Patient Safety Foundation in 2008, and has been recognized with the AHA/ASA Gold-Plus (Sustained) Achievement Award for three consecutive years. Virginia Mason is known for patient-centric care, a focus on improving quality and safety, and a dedication to achieving superior outcomes for patients. Our program is currently supported by 8 neurologists, including one board-certified neurointensivist, who share coverage responsibilities for our stroke and inpatient populations. In addition, an ARNP stroke coordinator and dedicated neuro clinical nurse specialist support the day-to-day inpatient care and stroke program operations. A superb group of neurosurgeons and neurointerventional radiologists provide patients access to the latest in cutting-edge intracranial and endovascular therapy. Email: gail.donovan@vmmc.org

Neurologist Excellent opportunity to join established and respected Neurology Group in the Portland, OR metro area to assume an established practice. Physician support by local hospital with either practice support income guarantee or full time hospital employment. Competitive compensation package includes travel, relocation allowance and signing bonus. Contact Barbara Hills at barbhillsmd@gmail.com

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TECFIDERATM (dimethyl fumarate) delayed-release capsules, for oral use

Brief Summary of Full Prescribing Information

1 INDICATIONS AND USAGE

TECFIDERA is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Lymphopenia

TECFIDERA may decrease lymphocyte counts [see Adverse Reactions (6.1)]. In the MS placebo controlled trials, mean lymphocyte counts decreased by approximately 30% during the first year of treatment with TECFIDERA and then remained stable. Four weeks after stopping TECFIDERA, mean lymphocyte counts increased but did not return to baseline. Six percent (6%) of TECFIDERA patients and <1% of placebo patients experienced lymphocyte counts <0.5x10^9/L (lower limit of normal 0.91x10^9/L). The incidence of infections (60% vs 58%) and serious infections (2% vs 2%) was similar in patients treated with TECFIDERA or placebo, respectively. There was no increased incidence of serious infections observed in patients with lymphocyte counts <0.8x10^9/L or 0.5x10^9/L.

Before initiating treatment with TECFIDERA, a recent CBC (i.e., within 6 months) should be available. A CBC is recommended annually, and as clinically indicated. Withholding treatment should be considered in patients with serious infections until the infection(s) is resolved. TECFIDERA has not been studied in patients with pre-existing low lymphocyte counts.

5.2 Flushing

TECFIDERA may cause flushing (e.g., warmth, redness, itching, and/or burning sensation). In clinical trials, 40% of TECFIDERA treated patients experienced flushing. Flushing symptoms generally began soon after initiating TECFIDERA and usually improved or resolved over time. In the majority of patients who experienced flushing, it was mild or moderate in severity. Three percent (3%) of patients discontinued TECFIDERA for flushing and <1% had serious flushing symptoms that were not life-threatening but led to hospitalization. Administration of TECFIDERA with food may reduce the incidence of flushing.

6 ADVERSE REACTIONS

The following important adverse reactions are described elsewhere in labeling: Lymphopenia, Flushing [see Warnings and Precautions (5.1, 5.2)].

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in 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.

The most common adverse reactions (incidence ≥10% and ≥2% more than placebo) for TECFIDERA were flushing, abdominal pain, diarrhea, and nausea.

Adverse Reactions in Placebo-Controlled Trials

In the two well-controlled studies demonstrating effectiveness, 1529 patients received TECFIDERA with an overall exposure of 2244 person-years [see Clinical Studies (14)].

The adverse reactions presented in the table below are based on safety information from 769 patients treated with TECFIDERA 240 mg twice a day and 771 placebo-treated patients.

<table>
<thead>
<tr>
<th>Blood and Lymphatic System Disorders</th>
<th>TECFIDERA N=769</th>
<th>Placebo N=771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphopenia</td>
<td>2%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal Disorders</th>
<th>TECFIDERA N=769</th>
<th>Placebo N=771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Nausea</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vascular Disorders</th>
<th>TECFIDERA N=769</th>
<th>Placebo N=771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flushing</td>
<td>40%</td>
<td>6%</td>
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<table>
<thead>
<tr>
<th>Skin and Subcutaneous Tissue Disorders</th>
<th>TECFIDERA N=769</th>
<th>Placebo N=771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pruritus</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Rash</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Erythema</td>
<td>5%</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigations</th>
<th>TECFIDERA N=769</th>
<th>Placebo N=771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin urine present</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Aspartate aminotransferase increased</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Gastrointestinal

TECFIDERA caused GI events (e.g., nausea, vomiting, diarrhea, abdominal pain, and dyspepsia). The incidence of GI events was higher early in the course of treatment (primarily in month 1) and usually decreased over time in patients treated with TECFIDERA compared with placebo. Four percent (4%) of patients treated with TECFIDERA and less than 1% of placebo patients discontinued due to gastrointestinal events. The incidence of serious GI events was 1% in patients treated with TECFIDERA.

Hepatic Transaminases

An increased incidence of elevations of hepatic transaminases in patients treated with TECFIDERA was seen primarily during the first six months of treatment and most patients with elevations had levels < 3 times the upper limits of normal (ULN). Elevations of alanine aminotransferase and aspartate aminotransferase to ≥ 3 times the ULN occurred in a small number of patients treated with both TECFIDERA and placebo and were balanced between groups. There were no elevations in transaminases ≥ 3 times the ULN with concomitant elevations in total bilirubin > 2 times the ULN. Discontinuations due to elevated hepatic transaminases were < 1% and were similar in patients treated with TECFIDERA or placebo.

Eosinophilia

A transient increase in mean eosinophil counts was seen during the first 2 months of therapy.
Adverse Reactions in Placebo-Controlled and Uncontrolled Studies

In placebo-controlled and uncontrolled clinical studies, a total of 2513 patients have received TECFIDERA and been followed for periods up to 4 years with an overall exposure of 4603 person-years. Approximately 1162 patients have received more than 2 years of treatment with TECFIDERA. The adverse reaction profile of TECFIDERA in the uncontrolled clinical studies was consistent with the experience in the placebo-controlled clinical trials.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

There are no adequate and well-controlled studies in pregnant women. In animals, adverse effects on offspring survival, growth, sexual maturation, and neurobehavioral function were observed when dimethyl fumarate (DMF) was administered during pregnancy and lactation at clinically relevant doses. TECFIDERA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

In rats administered DMF orally (25, 100, 250 mg/kg/day) throughout organogenesis, embryofetal toxicity (reduced fetal body weight and delayed ossification) were observed at the highest dose tested. This dose also produced evidence of maternal toxicity (reduced body weight). Plasma exposure (AUC) for monomethyl fumarate (MMF), the major circulating metabolite, at the no-effect dose is approximately three times that in humans at the recommended human dose (RHD) of 480 mg/day. In rabbits administered DMF orally (25, 75, and 150 mg/kg/day) throughout organogenesis, embryolethality and decreased maternal body weight were observed at the highest dose tested. The plasma AUC for MMF at the no-effect dose is approximately 5 times that in humans at the RHD.

Oral administration of DMF (25, 100, and 250 mg/kg/day) to rats throughout organogenesis and lactation resulted in increased lethality, persistent reductions in body weight, delayed sexual maturation (male and female pups), and reduced testicular weight at the highest dose tested. Neurobehavioral impairment was observed at all doses. A no-effect dose for developmental toxicity was not identified. The lowest dose tested was associated with plasma AUC for MMF lower than that in humans at the RHD.

Pregnancy Registry

There is a pregnancy registry that monitors pregnancy outcomes in women exposed to TECFIDERA during pregnancy. Encourage patients to enroll by calling 1-800-456-2255.

8.3 Nursing Mothers

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when TECFIDERA is administered to a nursing woman.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

Clinical studies of TECFIDERA did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients.

17 PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information)

17.1 Dosage

Inform patients that they will be provided two strengths of TECFIDERA when starting treatment: 120 mg capsules for the 7 day starter dose and 240 mg capsules for the maintenance dose, both to be taken twice daily. Inform patients to swallow TECFIDERA capsules whole and intact. Inform patients to not crush, chew, or sprinkle capsule contents on food. Inform patients that TECFIDERA can be taken with or without food [see Dosage and Administration (2.1)].

17.2 Flushing and Gastrointestinal (GI) Reactions

Flushing and GI reactions (abdominal pain, diarrhea, and nausea) are the most common reactions, especially at the initiation of therapy, and may decrease over time. Advise patients to contact their healthcare provider if they experience persistent and/or severe flushing or GI reactions, as taking TECFIDERA with food may help [see Adverse Reactions (6.1)].

17.3 Pregnancy and Pregnancy Registry

Instruct patients that if they are pregnant or plan to become pregnant while taking TECFIDERA they should inform their physician.

Encourage patients to enroll in the TECFIDERA Pregnancy Registry if they become pregnant while taking TECFIDERA. Advise patients to call 1-800-456-2255 for more information [see Use in Specific Populations (8.1)].

17.4 Lymphocyte Counts

Inform patients that TECFIDERA may decrease lymphocyte counts. A recent blood test (i.e., within 6 months) should be available before they start therapy to identify patients with pre-existing low lymphocyte counts. Blood tests are also recommended annually, and as clinically indicated [see Warnings and Precautions (5.1), Adverse Reactions (6.1)].
For relapsing forms of multiple sclerosis,
when it’s time to treat,
it’s time for

Tecfidera®
(dimethyl fumarate) delayed-release capsules 240 mg

For more information, please visit TecfideraHCP.com

Indication
Tecfidera is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

Important Safety Information
Tecfidera may decrease lymphocyte counts; in clinical trials there was a ~30% reduction during the first year which then remained stable. Four weeks after stopping Tecfidera, mean lymphocyte counts increased but not to baseline. 6% of Tecfidera patients and <1% of placebo patients had lymphocyte counts <0.5x10^9/L. Tecfidera has not been studied in patients with pre-existing low lymphocyte counts. The incidence of infections and serious infections was similar in patients treated with Tecfidera or placebo. Consider withholding treatment in patients with serious infections until resolved. A complete blood count is recommended within 6 months before initiating treatment, annually, and as clinically indicated.

Tecfidera may cause flushing (e.g. warmth, redness, itching, and/or burning sensation). 40% of patients taking Tecfidera reported flushing which was mostly mild to moderate in severity. Three percent of patients discontinued Tecfidera for flushing and <1% had serious flushing events that led to hospitalization. Taking Tecfidera with food may reduce flushing.

Tecfidera may cause gastrointestinal (GI) events (e.g., nausea, vomiting, diarrhea, abdominal pain, and dyspepsia). Four percent of Tecfidera patients and <1% placebo patients discontinued due to GI events. The incidence of serious GI events was 1%. The most common adverse reactions associated with Tecfidera versus placebo are flushing (40% vs 6%) and GI events: abdominal pain (18% vs 10%), diarrhea (14% vs 11%), nausea (12% vs 9%).

Elevations in hepatic transaminases have been reported. A transient increase in mean eosinophil counts was seen during the first two months. Tecfidera should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Encourage patients who become pregnant while taking Tecfidera to enroll in the Tecfidera pregnancy registry by calling 1-800-456-2255.

For additional important safety information, please see Brief Summary of full Prescribing Information on the following pages.