HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

NATALIZUMAB PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Natalizumab** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Quantity: _____ vials	Refills:
Directions: ☐300 mg SQ every 4 weeks		☐other: _____	
Diagnosis *(submit documentation)*:		Dx code *(required)*:	
Is the beneficiary currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		
Is natalizumab prescribed by or in consultation with a neurologist or gastroenterologist?		☐Yes ☐No	*Submit documentation of consultation if applicable.*
Is the beneficiary receiving chronic immunosuppressive or immune modulating therapies?		☐Yes ☐No	*Submit complete medication list.*

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of MULTIPLE SCLEROSIS (MS):

☐Has a relapsing form of MS

2. For treatment of CROHN'S DISEASE (CD):

☐Has moderate-to-severe CD AND:
- ☐Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
- ☐Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, 6-MP, MTX)

☐Has CD that is associated with high-risk or poor prognostic features

☐Has achieved remission with the requested medication AND:
- ☐Will be using the requested medication as maintenance therapy to maintain remission

☐Tried and failed a TNF-inhibitor (e.g., Cimzia, Humira, Remicade) or has a contraindication or an intolerance to TNF-inhibitors

☐ Tried and failed or has a contraindication or an intolerance to ustekinumab (Stelara)
☐ Tried and failed or has a contraindication or intolerance to vedolizumab (Entyvio)

3. For a NON-PREFERRED natalizumab product:

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred natalizumab product(s) approved or medically accepted for the beneficiary's diagnosis

RENEWAL requests

1. For treatment of MULTIPLE SCLEROSIS (MS):

☐ Experienced improvement or stabilization of the MS disease course since starting natalizumab

2. For treatment of CROHN'S DISEASE:

☐ Experienced therapeutic benefit within 3 months of starting natalizumab
☐ Was able to discontinue concomitant steroid use within 6 months of starting natalizumab (if applicable)
☐ **Has been using natalizumab for at least 1 year AND:**
  ☐ Has not required additional steroid use for disease control for more than 3 months in the past 12 months

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: