

ISSUE DATE November 24, 2020	EFFECTIVE DATE January 5, 2021	NUMBER *See below
SUBJECT Prior Authorization of Tysabri (natalizumab) – Pharmacy Services		BY  Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Tysabri (natalizumab) submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Tysabri (natalizumab) will be utilized in the MA fee-for-service delivery system and by the MA managed care organizations (MCOs) in Physical Health HealthChoices and Community HealthChoices. Providers rendering services in the MA managed care delivery system should address any questions related to the prior authorization of Tysabri (natalizumab) to the appropriate MCO.

BACKGROUND:

*01-20-48	09-20-47	27-20-43	33-20-44
02-20-41	11-20-41	30-20-40	
03-20-41	14-20-42	31-20-48	
08-20-51	24-20-42	32-20-40	

<p>COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:</p> <p>The appropriate toll-free number for your provider type.</p> <p>Visit the Office of Medical Assistance Programs Web site at https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx.</p>

The Department of Human Services' (Department) Drug Utilization Review (DUR) Board meets semi-annually to review provider prescribing and dispensing practices for efficacy, safety, and quality and to recommend interventions for prescribers and pharmacists through the Department's Prospective Drug Use Review and Retrospective Drug Use Review programs.

DISCUSSION:

During the October 21, 2020, meeting, the DUR Board recommended the following revisions to the guidelines to determine medical necessity of Tysabri (natalizumab):

- Addition of a guideline that Tysabri (natalizumab) is prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication;
- Addition of a guideline that the beneficiary is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;
- Addition of a guideline that the beneficiary is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;
- Addition of a guideline that Tysabri (natalizumab) is prescribed by or in consultation with an appropriate specialist (i.e., a neurologist for a diagnosis of multiple sclerosis or a gastroenterologist for a diagnosis of Crohn's disease);
- Addition of a guideline that the beneficiary does not have a history of a contraindication to Tysabri (natalizumab);
- Removal of the guidelines related to initial requests for the treatment of multiple sclerosis;
- Revision of the guidelines related to the treatment of Crohn's disease to address the place in therapy of Tysabri (natalizumab) based on current medical literature and to be consistent with the guidelines for Crohn's disease that are included in the Cytokine and CAM Antagonists prior authorization guidelines;
- Addition of a guideline specifying that prescriptions for Tysabri (natalizumab) that exceed the quantity limit will require prior authorization;
- Removal of the guideline related to anti-JC virus testing for requests for renewal of prior authorization; and
- Reformatting of the Dose and Duration of Therapy section for clarity and consistency with other prior authorization guidelines.

The revisions to the guidelines to determine medical necessity of Tysabri (natalizumab), as recommended by the DUR Board, were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Tysabri (natalizumab) are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Tysabri (natalizumab)) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements

<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx>

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines

<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx>

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Tysabri (natalizumab)

A. Prescriptions That Require Prior Authorization

All prescriptions for Tysabri (natalizumab) must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for Tysabri (natalizumab), the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed Tysabri (natalizumab) for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Is prescribed Tysabri (natalizumab) by or in consultation with an appropriate specialist (i.e., a neurologist for a diagnosis of multiple sclerosis or a gastroenterologist for a diagnosis of Crohn's disease); **AND**
5. Does not have a contraindication to Tysabri (natalizumab); **AND**
6. Is not receiving chronic immunosuppressant or immunomodulator therapy; **AND**
7. For treatment of Crohn's disease, **both** of the following:
 - a. **One** of the following:
 - i. For a diagnosis of moderate-to-severe Crohn's disease, **one** of the following:
 - a) Failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
 - b) **One** of the following:
 - (i) Failed to maintain remission with an immunomodulator in accordance with current consensus guidelines¹

¹ e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO], World Gastroenterology Organization [WGO]

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- (ii) Has a contraindication or intolerance to immunomodulators in accordance with current consensus guidelines,¹
- ii. Has a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s),²
- iii. **Both** of the following:
 - a) Has achieved remission with Tysabri (natalizumab)
 - b) Will be using Tysabri (natalizumab) as maintenance therapy to maintain remission
- b. **One** of the following:
 - i. Has a history of therapeutic failure of at least 1 tumor necrosis factor (TNF) inhibitor indicated or medically accepted for the treatment of Crohn's disease,
 - ii. Has a history of contraindication or intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease,
 - iii. Has a current history (within the past 90 days) of being prescribed Tysabri (natalizumab);

AND

- 8. If a prescription for Tysabri (natalizumab) is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. See Quantity Limits List: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR TYSABRI (NATALIZUMAB): The determination of medical necessity of a request for renewal of a prior authorization for Tysabri (natalizumab) that was previously approved will take into account whether the beneficiary:

- 1. For a diagnosis of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course; **AND**

² Examples of high-risk or poor prognostic features in patients with Crohn's disease include: initial diagnosis or clinical evidence supports the onset of symptoms at <30 years of age, extensive anatomic involvement, perianal and/or severe rectal disease, deep ulcers on colonoscopy, prior surgical resection, stricturing and/or penetrating behavior (AGA, 2014), need for steroid therapy at initial diagnosis, extra-intestinal manifestations (e.g., arthropathy, metabolic bone disease, cardiopulmonary disease, hepatobiliary disease, erythema nodosum, pyoderma gangrenosum, Sweet's syndrome, venous thromboembolism) (ECCO, 2017), and laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, and high fecal calprotectin levels (CAG, 2019).

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2. For a diagnosis of Crohn's disease, **both** of the following:
 - a. **One** of the following:
 - i. Has documentation of therapeutic benefit within 3 months of starting therapy
 - ii. Was able to discontinue concomitant corticosteroid use within 6 months of starting therapy
 - b. Did not require additional steroid use for disease control for more than 3 months in a calendar year;

AND

3. If a prescription for Tysabri (natalizumab) is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. See Quantity Limits List: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for Tysabri (natalizumab). If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the service is medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Tysabri (natalizumab) will be approved as follows:

1. For a diagnosis of multiple sclerosis:
 - a. Initial requests will be approved for up to 6 months.
 - b. Renewal requests will be approved for up to 12 months.
2. For a diagnosis of Crohn's disease:

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- a. If the beneficiary is not taking chronic oral corticosteroids when starting Tysabri (natalizumab), initial requests will be approved for up to 3 months.
- b. If the beneficiary is taking chronic oral corticosteroids when starting Tysabri (natalizumab), initial requests will be approved for up to 6 months to allow tapering of the corticosteroids.
- c. Renewal requests will be approved for up to 12 months.

E. References

1. Tysabri Package Insert. Cambridge, MA: Biogen Inc., June 2020.
2. Goodin, DS et.al. Assessment: the use of natalizumab (Tysabri) for the treatment of multiple sclerosis (an evidence-based review). Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology*. 2008;71;766-773.
3. Goodin DS, et.al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. *Neurology*. 2002 Jan 22;58(2):169-78.
4. Olek MJ, Mowry E. Disease-modifying treatment of relapsing-remitting multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated July 10, 2020. Accessed July 28, 2020.
5. Rae-Grant A et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis. Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology* 2018 Apr 24; 90:777. doi.org/10.1212/WNL.0000000000005347.
6. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG clinical guideline: management of Crohn's disease in adults. *Am J Gastroenterol*. 2018;113(4):481-517.
7. Gomollón F, Dignass A, Annese V, et al. 3rd European evidence-based consensus on the diagnosis and management of Crohn's disease 2016: part 1: diagnosis and medical management. *J Crohns Colitis*. 2017;11(1):3-25.
8. Gionchetti P, Dignass A, Danese S, et al. 3rd European evidence-based consensus on the diagnosis and management of Crohn's disease 2016: part 2: surgical management and special situations. 2017;11(2):135-149.
9. Nelson SM, Nguyen TM, McDonald JW, MacDonald JK. Natalizumab for induction of remission Crohn's disease. *Cochrane Database Syst Rev*. 2018;8:CD006097.
10. Torres J, Bonovas S, Doherty G, et al. ECCO guidelines on therapeutics in Crohn's disease: medical treatment. *J Crohns Colitis*. 2020;14(1):4-22.