pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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

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☐ 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 DHS – PHARMACY DIVISION

Prescriber Signature:	Date: