

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

Prior authorization guidelines for **Natalizumab** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request <input type="checkbox"/> 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: <input type="checkbox"/> 300 mg SQ every 4 weeks <input type="checkbox"/> other: _____			
Diagnosis ( <u>submit documentation</u> ):		Dx code ( <u>required</u> ):	
Is the beneficiary currently being treated with the requested medication?	<input type="checkbox"/> Yes – date of last dose: _____ <i>Submit documentation.</i> <input type="checkbox"/> No		
Is natalizumab prescribed by or in consultation with a neurologist or gastroenterologist?	<input type="checkbox"/> Yes <i>Submit documentation of consultation if applicable.</i> <input type="checkbox"/> No		
Is the beneficiary receiving chronic immunosuppressive or immune modulating therapies?	<input type="checkbox"/> Yes <i>Submit complete medication list.</i> <input type="checkbox"/> No		

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

***Check all that apply and submit documentation for each item.***

**INITIAL requests**

<b>1. For treatment of MULTIPLE SCLEROSIS (MS):</b> <input type="checkbox"/> Has a relapsing form of MS
<b>2. For treatment of CROHN'S DISEASE (CD):</b> <input type="checkbox"/> Has moderate-to-severe CD AND: <input type="checkbox"/> Tried and failed to <u>achieve remission</u> with or has a contraindication or an intolerance to an induction course of corticosteroids <input type="checkbox"/> Tried and failed to <u>maintain remission</u> with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, 6-MP, MTX) <input type="checkbox"/> Has CD that is associated with high-risk or poor prognostic features <input type="checkbox"/> Has achieved remission with the requested medication AND: <input type="checkbox"/> 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 submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

**Prescriber Signature:**

**Date:**

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