



NATALIZUMAB PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Natalizumab** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

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|--------------------------------------|--|--------------------|------------------|------------------|
| <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

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|--|--|------------------------------|----------|
| 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

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| <p>1. For treatment of MULTIPLE SCLEROSIS (MS):</p> <p><input type="checkbox"/> Has a relapsing form of MS</p> |
| <p>2. For treatment of CROHN'S DISEASE (CD):</p> <p><input type="checkbox"/> Has moderate-to-severe CD</p> <p><input type="checkbox"/> Has CD that is associated with high-risk or poor prognostic features</p> <p><input type="checkbox"/> Has achieved remission with the requested medication AND:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Will be using the requested medication as maintenance therapy to maintain remission</p> <p><input type="checkbox"/> Tried and failed a TNF-inhibitor (e.g., Cimzia, Humira, Remicade) or has a contraindication or an intolerance to TNF-inhibitors</p> <p><input type="checkbox"/> Tried and failed an IL-12/23 or IL-23 inhibitor (e.g., Skyrizi, Stelara, Tremfya) or has a contraindication or an intolerance to IL-12/23 and IL-23 inhibitors</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or intolerance to vedolizumab (Entyvio)</p> |



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

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

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

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|------------------------------|--------------|
| Prescriber Signature: | Date: |
|------------------------------|--------------|

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