Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Natalizumab

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for a renewal of an authorization

☐ Yes ☐ No

Q2. Is the patient prescribed the requested medication 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?

☐ Yes ☐ No

Q3. Is the requested medication age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the patient prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the patient prescribed the requested medication 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)?

Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Natalizumab

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:

☐ Yes ☐ No

Q6. Does the patient have a contraindication to Tysabri (natalizumab)?

☐ Yes ☐ No

Q7. Does the patient have the diagnosis of moderately-to-severely active Crohn's disease with inflammation?

☐ Yes ☐ No

Q8. Has the patient failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids?

☐ Yes ☐ No

Q9. Has the patient failed to maintain remission with an immunomodulator in accordance with current consensus guidelines OR does the patient have a contraindication or intolerance to immunomodulators in accordance with current consensus guidelines?

☐ Yes ☐ No

Q10. Does the patient have Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s) (e.g., 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)?

☐ Yes ☐ No

Q11. Has the patient achieved remission with the requested medication?

☐ Yes ☐ No

Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Natalizumab

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:

Q12. Will the patient be using the requested medication as maintenance therapy to maintain remission?

☐ Yes ☐ No

Q13. Does the patient 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?

☐ Yes ☐ No

Q14. Does the patient have a history of contraindication or intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease?

☐ Yes ☐ No

Q15. Does the patient have a current history (within the past 90 days) of being prescribed the requested medication?

☐ Yes ☐ No

Q16. Is the patient taking chronic oral corticosteroids when starting the requested medication?

☐ Yes ☐ No

Q17. Is this a request for a renewal of an authorization for Multiple Sclerosis?

☐ Yes ☐ No

Q18. Is there documentation of improvement or stabilization of the multiple sclerosis disease course?

☐ Yes ☐ No

Q19. For Crohn's disease, is there documentation of therapeutic benefit within 3 months of starting therapy?

☐ Yes ☐ No

Q20. Was the patient able to discontinue concomitant corticosteroid use within 6 months of starting therapy?

Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Natalizumab

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:

☐ Yes ☐ No

Q21. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred natalizumab product(s)?

☐ Yes ☐ No

Q22. Has the patient received the non-preferred natalizumab product within the last 90 days (does not apply to non-preferred brands when the interchangeable biosimilar or unbranded biologic is preferred or to non-preferred interchangeable biosimilars or unbranded biologics when the therapeutically equivalent interchangeable brand or brand biologic product is preferred)?

☐ Yes ☐ No

Q23. Is there documentation that the patient did not require additional steroid use for disease control for more than 3 months in a calendar year?

☐ Yes ☐ No

Q24. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2024