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

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Natalizumab** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐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:	
Member name:		City/state/zip:	
Member 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 member 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 member receiving chronic immunosuppressive or immune modulating therapies?	☐Yes ☐No	*Submit complete medication list.*	

Complete all sections that apply to the member 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
☐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
☐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

☐ 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 member'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 member's diagnosis

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)