Clinical Policy: Natalizumab

Reference Number: PHW.PDL.043.01
Effective Date: 01/01/2020
Last Review Date: 11/2024

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health and Wellness® that Natalizumab is **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of A Natalizumab Product

A. Prescriptions That Require Prior Authorization

All prescriptions for natalizumab product must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for natalizumab product, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is 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; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is 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); **AND**

5. Does not have a contraindication to the requested medication; **AND**

6. Is not receiving chronic immunosuppressant or immunomodulator therapy; **AND**

7. For treatment of Crohn's disease, **both** of the following:

a. **One** of the following:

i. For a diagnosis of moderate to severe Crohn's disease, **one** of the following:

a) Failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids

b) **One** of the following:

(i) Failed to maintain remission with an immunomodulator in accordance with current consensus guidelines[1]
(ii) Has a contraindication or an intolerance to immunomodulators in accordance with current consensus guidelines,[1]

ii. Has a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s),[2]

iii. **Both** of the following:

a) Has achieved remission with the requested medication
b) Will be using the requested medication as maintenance therapy to maintain remission

b. **One** of the following:

i. **All** of the following:

a) **One** of the following:

(i) Has 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
(ii) Has a contraindication or an intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease,

b) Has a history of therapeutic failure of or a contraindication or an intolerance to ustekinumab,

c) Has a history of therapeutic failure of or a contraindication or an

[1] e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO]
[2] Examples of high-risk or poor prognostic features in patients with Crohn's disease include: initial diagnosis or clinical evidence supports the onset of symptoms at <30 years of age, extensive anatomic involvement, presence of fistula, perianal and/or severe rectal disease, large or deep mucosal lesions on endoscopy or imaging, prior surgical resection, stricturing and/or penetrating behavior, need for steroid therapy at initial diagnosis, extra-intestinal manifestations, and laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, and high fecal calprotectin levels (AGA 2014; ECCO 2017; CAG 2019; AGA 2021).

intolerance to vedolizumab;

ii. Has a current history (within the past 90 days) of being prescribed a natalizumab product;

AND

8. For a non-preferred natalizumab product, **one** of the following:

   a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred natalizumab product(s) approved or medically accepted for the member's diagnosis
   b. Has a current history (within the past 90 days) of being prescribed the same non-preferred natalizumab product (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)

   See the Preferred Drug List (PDL) for the list of preferred natalizumab products at: https://papdl.com/preferred-drug-list;

   AND

9. If a prescription for the requested medication is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR A NATALIZUMAB PRODUCT: The determination of medical necessity of a request for renewal of a prior authorization for a natalizumab product that was previously approved will take into account whether the member:

1. For a diagnosis of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course; **AND**

2. For a diagnosis of Crohn's disease, **both** of the following:

   a. **One** of the following:

      i. Has documentation of therapeutic benefit within 3 months of starting therapy

ii. Was able to discontinue concomitant corticosteroid use within 6 months of starting therapy

b. Did not require additional steroid use for disease control for more than 3 months in a calendar year;

AND

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND

4. Is 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); AND

5. For a non-preferred natalizumab product with a therapeutically equivalent interchangeable biosimilar or brand or unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent interchangeable biosimilar or brand or unbranded biologic that would not be expected to occur with the requested medication.

6. If a prescription for the requested medication is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a natalizumab product. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the service is medically necessary to meet the medical needs of the member.

D. **Approval Duration:**

PA Health & Wellness will limit authorization of a natalizumab product as follows:

1. For a diagnosis of multiple sclerosis:

    a. Initial requests will be approved for up to 6 months.
    b. Renewal requests will be approved for up to 12 months.

2. For a diagnosis of Crohn's disease:

    a. If the member is not taking chronic oral corticosteroids when starting the requested medication, initial requests will be approved for up to 3 months.
    b. If the member is taking chronic oral corticosteroids when starting the requested medication, initial requests will be approved for up to 6 months to allow tapering of the corticosteroids.
    c. Renewal requests will be approved for up to 12 months.

E. References

1. Tysabri Package Insert. Cambridge, MA: Biogen Inc., June 2020.
2. Goodin DS et.al. Assessment: the use of natalizumab (Tysabri) for the treatment of multiple sclerosis (an evidence-based review). Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Neurology. 2008;71;766-773.
3. Goodin DS et.al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan 22;58(2):169-78.
4. Olek MJ, Mowry E. Disease-modifying treatment of relapsing-remitting multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated July 10, 2020. Accessed July 28, 2020.
5. Rae-Grant A et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis. Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology 2018 Apr 24; 90:777. doi.org/10.1212/WNL.0000000000005347.
6. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG clinical guideline: management of Crohn's disease in adults. Am J Gastroenterol. 2018;113(4):481-517.
7. Gomollón F, Dignass A, Annese V, et al. 3rd European evidence-based consensus on the diagnosis and management of Crohn's disease 2016: part 1: diagnosis and medical management. J Crohns Colitis. 2017;11(1):3-25.
8. Gionchetti P, Dignass A, Danese S, et al. 3rd European evidence-based consensus on the diagnosis and management of Crohn's disease 2016: part 2: surgical management and special situations. 2017;11(2):135-149.
9. Nelson SM, Nguyen TM, McDonald JW, MacDonald JK. Natalizumab for induction of remission Crohn's disease. Cochrane Database Syst Rev. 2018;8:CD006097.

10. Torres J, Bonovas S, Doherty G, et al. ECCO guidelines on therapeutics in Crohn's disease: medical treatment. J Crohns Colitis. 2020;14(1):4-22.
11. Feuerstein JD, Ho EY, Shmidt E, et al. AGA clinical practice guidelines on the medical management of moderate to severe luminal and perianal fistulizing Crohn's disease. Gastroenterology. 2021;160:2496-2508.
12. Torres J, Bonovas S, Doherty G, et al. ECCO guidelines on therapeutics in Crohn's disease: medical treatment. J Crohns Colitis. 2020;14(1):4-22.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022: policy revised according to DHS revisions effective 01/03/2022	10/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024: policy revised according to DHS revisions effective 01/08/2024	11/2023
Q1 2025: policy revised according to DHS revisions effective 01/06/2025	11/2024