HEALTH PARTNERS PLANS
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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member 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. The requested drug was previously approved. If YES, go to 9.

☐ Yes ☐ No

Q2. The member meets ALL of the following:

☐ Is prescribed the requested drug 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

☐ Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

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

☐ Is prescribed the requested drug 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)

☐ Does not have a contraindication to the requested drug

☐ Is not receiving chronic immunosuppressant or immunomodulator therapy

Q3. For treatment of CROHN'S DISEASE, one of the following:

☐ Has a diagnosis of moderate to severe Crohn's disease

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Member Name:	Prescriber Name:

☐ Has a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s)

☐ Has achieved remission with the requested drug OR will be using the requested drug as maintenance therapy to maintain remission

Q4. The member meets ONE of the following:

☐ Has a history of therapeutic failure of at least one tumor necrosis factor (TNF) inhibitor indicated or medically accepted for the treatment of Crohn's disease

☐ Has a contraindication or an intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease

Q5. The member meets ONE of the following:

☐ Has a history of therapeutic failure of at least one IL-12/23 or IL-23 inhibitor indicated or medically accepted for the treatment of Crohn's disease

☐ Has a contraindication or an intolerance to the IL-12/23 and IL-23 inhibitors indicated or medically accepted for the treatment of Crohn's disease

Q6. Has a history of therapeutic failure of or a contraindication or an intolerance to vedolizumab.

☐ Yes ☐ No

Q7. Has a current history (within the past 90 days) of being prescribed a natalizumab product.

☐ Yes ☐ No

Q8. For a non-preferred natalizumab product, 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 beneficiary's diagnosis. See the Preferred Drug List (PDL) for the list of preferred natalizumab products at: https://papdl.com/preferred-drug-list.

☐ Yes ☐ No

Q9. For a diagnosis of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course.

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q10. For a diagnosis of Crohn's disease, ONE of the following:

☐ Has documentation of therapeutic benefit within three months of starting therapy

☐ Was able to discontinue concomitant corticosteroid use within six months of starting therapy

Q11. Did not require additional steroid use for disease control for more than three months in a calendar year.

☐ Yes ☐ No

Q12. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q13. Is prescribed the requested drug 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).

☐ Yes ☐ No

Q14. For a non-preferred natalizumab product, 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 beneficiary's diagnosis. See the PDL for the list of preferred natalizumab products at: https://papdl.com/preferred-drug-list.

☐ Yes ☐ No

Q15. Additional Information:

Prescriber Signature _____ Date _____

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