

# SENTARA HEALTH PLANS

## MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-668-1550.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

**For Medicare Members:** Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Additional indications may be covered at the discretion of the health plan.

**Drug Requested:** Tysabri® (natalizumab) IV (J2323) (Medical)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member Sentara #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

### **Recommended Dosing:**

- IV: 300 mg infused over 1 hour every 4 weeks = 300 billable units every 28 days
- One (1) 300 mg/15 mL vial = 300 billable units

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**DIAGNOSIS – Multiple Sclerosis (MS)**

(Continued on next page)

- Prescriber is a Neurologist
- Member has a confirmed diagnosis of relapsing-remitting MS
- Member has had at least **ONE** medically documented clinical relapse within the previous 12 months
- Member is registered with the Tysabri® risk management program known as TOUCH™
- Member meets **ONE** of the following:
  - Member has tried and failed at least **ONE (1)** of the following agents (**verified by chart notes or pharmacy paid claims; check each tried**):

<input type="checkbox"/> dimethyl fumarate (Tecfidera®)	<input type="checkbox"/> Glatopa® or glatiramer acetate (Copaxone®)
<input type="checkbox"/> fingolimod (Gilenya®)	<input type="checkbox"/> teriflunomide (Aubagio®)

- Member's current or potential disease progression warrants the use of Tysabri®

**DIAGNOSIS – Crohn's Disease (CD)**

- Prescriber is a Gastroenterologist
- Member has moderate to severe active Crohn's disease with evidence of inflammation
- Member is registered with the Tysabri® risk management program known as CD TOUC™
- Member meets **ONE** of the following (**verified by chart notes or pharmacy/medical paid claims**):
  - Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - Member has tried and failed Renflexis® **AND** Humira®

**Medication being provided by (check box below that applies):**

- Location/site of drug administration:** \_\_\_\_\_  
**NPI or DEA # of administering location:** \_\_\_\_\_

**OR**

- Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****