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 (J-2323) (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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ 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.

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) Indication**

- ❑ 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™

(Continued on next page)

- ❑ Member has tried and failed at least **ONE (1)** of the following agents **(check all tried)**:

❑ Aubagio® (teriflunomide)	❑ Avonex® (IFN beta-1b)	❑ Bafiertam™ (monomethyl fumarate)
❑ Betaseron® (IFN beta-1a)	❑ Copaxone® (glatiramer acetate)	❑ Extavia® (IFN beta-1a)
❑ Gilenya® (fingolimod)	❑ Kesimpta® (ofatumumab)	❑ Mavenclad® (cladribine)
❑ Mayzent® (siponimod)	❑ Plegridy® (peginterferon beta-1a)	❑ Rebif® (IFN beta-1a)
❑ Tecfidera® (dimethyl fumarate)	❑ Vumerity® (diroximel fumarate)	❑ Zeposia® (ozanimod)

OR

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

❑ DIAGNOSIS – CROHN'S Indication

- ❑ 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 TOUCH™
- ❑ Member has had failure of conventional therapies: Budesonide or high dose steroids (prednisone 40-60mg)

OR

- ❑ Trial and failure of: ❑ 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 - PropriumRx**

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.*

***Approved by Pharmacy and Therapeutics Committee**: 3/20/2008
REVISED/UPDATED: ~~7/16/2009; 6/3/2011; 9/9/2011; 5/2/2012; 7/2/2012; 9/10/2012; 2/21/2013; 6/30/13; 5/8/2014; 8/18/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 7/18/2016; 9/22/2016; 12/11/2016; 7/24/2017; 9/18/2017; 5/24/2018; (Reformatted) 3/23/2019; 7/8/2019; 9/25/2019;~~ **6/30/2021**