



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Natalizumab

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health 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:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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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<input type="checkbox"/> Has a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s) <input type="checkbox"/> Has achieved remission with the requested drug OR will be using the requested drug as maintenance therapy to maintain remission

<p>Q4. The member meets ONE of the following:</p> <table style="width:100%;"> <tr> <td style="width:50%; padding: 5px;"><input type="checkbox"/> 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</td> <td style="width:50%; padding: 5px;"><input type="checkbox"/> Has a contraindication or an intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease</td> </tr> </table>	<input type="checkbox"/> 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	<input type="checkbox"/> Has a contraindication or an intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease
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<p>Q5. The member meets ONE of the following:</p> <table style="width:100%;"> <tr> <td style="width:50%; padding: 5px;"><input type="checkbox"/> 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</td> <td style="width:50%; padding: 5px;"><input type="checkbox"/> 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</td> </tr> </table>	<input type="checkbox"/> 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	<input type="checkbox"/> 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
<input type="checkbox"/> 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	<input type="checkbox"/> 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	

<p>Q6. Has a history of therapeutic failure of or a contraindication or an intolerance to vedolizumab.</p> <table style="width:100%;"> <tr> <td style="width:50%; padding: 5px;"><input type="checkbox"/> Yes</td> <td style="width:50%; padding: 5px;"><input type="checkbox"/> No</td> </tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<p>Q7. Has a current history (within the past 90 days) of being prescribed a natalizumab product.</p> <table style="width:100%;"> <tr> <td style="width:50%; padding: 5px;"><input type="checkbox"/> Yes</td> <td style="width:50%; padding: 5px;"><input type="checkbox"/> No</td> </tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<p>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.</p> <table style="width:100%;"> <tr> <td style="width:50%; padding: 5px;"><input type="checkbox"/> Yes</td> <td style="width:50%; padding: 5px;"><input type="checkbox"/> No</td> </tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<p>Q9. For a diagnosis of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course.</p> <table style="width:100%;"> <tr> <td style="width:50%; padding: 5px;"><input type="checkbox"/> Yes</td> <td style="width:50%; padding: 5px;"><input type="checkbox"/> No</td> </tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No	



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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

v2026-06