Clinical Policy: Natalizumab (Tysabri)
Reference Number: HIM.PA.SP17
Effective Date: 05/17
Last Review Date:
Line of Business: Health Insurance Marketplace

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Natalizumab (Tysabri®) is an integrin receptor antagonist.

FDA approved indication
Tysabri is indicated:

- As monotherapy for the treatment of patients with relapsing forms of multiple sclerosis (MS)
- For inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's disease (CD) with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-α

Limitation of use:

- Tysabri increases the risk of progressive multifocal leukoencephalopathy. When initiating and continuing treatment with Tysabri, physicians should consider whether the expected benefit of Tysabri is sufficient to offset this risk.
- In CD, Tysabri should not be used in combination with immunosuppressants or inhibitors of TNF-α.

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all)**:**

1. Diagnosis of relapsing MS established by magnetic resonance imaging (MRI);
2. Prescribed by or in consultation with a neurologist;
3. Failure of one of the following (a or b) unless contraindicated or clinically significant adverse effects are experienced:
   a. Betaseron or Rebif AND at least one of the following agents: glatiramer (Copaxone, Glatopa), Tecfidera, Gilenya, Aubagio;
   b. Any 2 of the following agents: glatiramer (Copaxone, Glatopa), Tecfidera, Gilenya, Aubagio;
4. Member will not use other disease modifying therapies for MS concurrently;
5. Dose does not exceed 300 mg every 4 weeks (1 vial every 4 weeks).

Approval duration: 6 months

B. Crohn's Disease (must meet all)**:**
1. Diagnosis of moderately to severely active CD and (a or b):
   a. Member has one of the following poor prognostic indicators for CD:
      i. Age < 18 years;
      ii. Perianal disease;
      iii. Upper gastrointestinal tract involvement;
      iv. Multiple extra-intestinal manifestations;
      v. Active tobacco use;
      vi. Perforating (i.e., fistulizing) disease;
   b. Failure of one of the following therapies (i or ii) unless contraindicated or member experiences clinically significant side effects:
      i. A biologic for CD other than Tysabri;
      ii. An immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], or methotrexate [MTX]) for ≥ 3 consecutive months;
2. Prescribed by or in consultation with a gastroenterologist;
3. Immunosuppressants (e.g., azathioprine, cyclosporine, 6-MP, MTX) and TNF-α inhibitors will not be administered concurrently *(note: aminosalicylates may be continued)*;
4. Dose does not exceed 300 mg every 4 weeks (1 vial every 4 weeks).

Approval duration: 6 months

C. Other diagnoses/indications
1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Multiple Sclerosis (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy (e.g., improved or maintained disease control evidenced by increase in Expanded Disability Status Scale (EDSS) or reduction in relapses or MRI lesions);
3. Member is not using other disease modifying therapies for MS concurrently;
4. If request is for a dose increase, new dose does not exceed 300 mg every 4 weeks (1 vial every 4 weeks).

Approval duration: 12 months

B. Crohn's Disease (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy;
3. Immunosuppressants (e.g., azathioprine, cyclosporine, 6-MP, MTX) and TNF-α inhibitors are not being administered concurrently *(note: aminosalicylates may be continued)*;
4. If request is for a dose increase, new dose does not exceed 300 mg every 4 weeks (1 vial every 4 weeks).

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PHAR.21 or evidence of coverage documents;

B. Primary progressive MS

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

6-MP: 6-mercaptopurine
CD: Crohn's disease
EDSS: Expanded Disability Status Scale
FDA: Food and Drug Administration
MRI: magnetic resonance imaging
MS: multiple sclerosis
MTX: methotrexate
TNF: tumor necrosis factor

V. References

1. Tysabri Prescribing Information. Cambridge, MA: Biogen Inc; May 2016. Available at http://www.tysabri.com. Accessed January 23, 2017.
2. Costello K, Halper J, Kalb R, Skutnik L, Rapp R. The use of disease-modifying therapies in multiple sclerosis, principles and current evidence – a consensus paper by the Multiple Sclerosis Coalition. July 2016. Accessed January 9, 2017.
3. Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002; 58(2): 169-178.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 revisions to the McDonald criteria. Ann Neurol. 2011; 69(2): 292-302.
5. Lichtenstein GR, Hanauer SB, Sandborn WJ, and the Practice Parameters Committee of the American College of Gastroenterology. Management of Crohn's disease in adults. Am J Gastroenterol. 2009; 104(2): 465-483.
6. Sandborn WJ. Crohn's disease evaluation and treatment: clinical decision tool. Gastroenterology 2014; 147: 702-705.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	01/17	05/17

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.