

Clinical Policy: Natalizumab (Tysabri)

Reference Number: MDN.CP.PHAR.259

Effective Date: 04.01.22

Last Review Date: 04.22

Line of Business: Meridian IL Medicaid

[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(s)

Tysabri is indicated:

- As monotherapy for the treatment of patients with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
- 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 tumor necrosis factor- α (TNF- α)

Limitation(s) 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 (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Tysabri is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all):

1. Diagnosis of one of the following (a, b, or c):
 - a. Clinically isolated syndrome;
 - b. Relapsing-remitting MS;
 - c. Secondary progressive MS;
2. Prescribed by or in consultation with a neurologist;
3. Age \geq 18 years;

4. **Applies to IL Medicaid only:** Failure of TWO of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):*
 - a. Gilenya[®];
 - b. Tecfidera[®];
 - c. An interferon-beta agent (Betaseron[®], Rebif[®]) or Copaxone[®];

**Prior authorization is required for Gilenya*
5. **Applies to MI Medicaid only:** Failure of ALL of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):*
 - a. Gilenya[®];
 - b. Tecfidera[®];
 - c. An interferon-beta agent (Betaseron[®], Avonex[®]) or Copaxone 20mg[®];
6. Tysabri is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
7. Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
8. Dose does not exceed 300 mg (1 vial) every 4 weeks.

Approval duration: 6 months

B. Crohn's Disease (must meet all):

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age \geq 18 years;
4. Member meets one of the following (a or b):
 - a. Failure of a \geq 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], methotrexate [MTX]) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. Medical justification supports inability to use immunomodulators (*see Appendix E*);
5. **Applies to IL Medicaid only:** Failure of Humira[®] AND Cimzia[®], each used for \geq 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;

**Prior authorization is required for Humira and Cimzia*
6. Tysabri is not prescribed concurrently with immunosuppressants (e.g., azathioprine, cyclosporine, 6-MP, MTX) or TNF- α inhibitors (note: aminosalicylates may be continued);
9. Dose does not exceed 300 mg (1 vial) every 4 weeks.

Approval duration: 6 months

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

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. Member meets one of the following (a or b):
 - a. If member has received < 1 year of total treatment: Member is responding positively to therapy;
 - b. If member has received ≥ 1 year of total treatment: Member meets one of the following (i, ii, iii, or iv):
 - i. Member has not had an increase in the number of relapses per year compared to baseline;
 - ii. Member has not had ≥ 2 new MRI-detected lesions;
 - iii. Member has not had an increase in EDSS score from baseline;
 - iv. Medical justification supports that member is responding positively to therapy;
3. Tysabri is not prescribed concurrently with other disease modifying therapies (*see Appendix D*);
4. If request is for a dose increase, new dose does not exceed 300 mg (1 vial) every 4 weeks.

Approval duration: 12months

B. Crohn's Disease (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Tysabri is not prescribed concurrently immunosuppressants (e.g., azathioprine, cyclosporine, 6-MP, MTX) or TNF- α inhibitors (note: aminosalicylates may be continued);
4. If request is for a dose increase, new dose does not exceed 300 mg (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.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

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 – CP.PMN.53 for Medicaid 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

GI: gastrointestinal

MS: multiple sclerosis

MTX: methotrexate

TNF- α : tumor necrosis factor- α

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>MS agents</i>		
Avonex [®] , Rebif [®] (interferon beta-1a)	Avonex: 30 mcg IM Q week Rebif: 22 mcg or 44 mcg SC TIW	Avonex: 30 mcg/week Rebif: 44 mcg TIW
Betaseron [®] (interferon beta-1b)	250 mcg SC QOD	250 mg QOD
Plegridy [®] (peginterferon beta-1a)	125 mcg SC Q2 weeks	125 mcg/2 weeks
glatiramer acetate (Copaxone [®] , Glatopa [®])	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Aubagio [®] (teriflunomide)	7 mg or 14 mg PO QD	14 mg/day
Gilenya [®] (fingolimod)	0.5 mg PO QD	0.5 mg/day
dimethyl fumarate (Tecfidera [®])	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day
<i>CD agents</i>		
6-mercaptopurine (Purixan [®])*	50 mg PO QD or 1.5 – 2 mg/kg/day PO	2 mg/kg/day
azathioprine (Azasan [®] , Imuran [®])*	1.5 – 2 mg/kg/day PO	2.5 mg/kg/day
corticosteroids*	prednisone 40 mg PO QD for 2 weeks or IV 50 – 100 mg Q6H for 1 week budesonide (Entocort EC [®]) 6 – 9 mg PO QD	Various
methotrexate (Otrexup [®] , Rasuvo)*	15 – 25 mg/week IM or SC	30 mg/week
Pentasa [®] (mesalamine)	1,000 mg PO QID	4 g/day
tacrolimus (Prograf [®])*	0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO	N/A
Cimzia [®] (certolizumab)	<u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks <u>Maintenance dose:</u> 400 mg SC every 4 weeks	400 mg every 4 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Humira [®] (adalimumab)	<p><u>Initial dose:</u> 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><u>Maintenance dose:</u> 40 mg SC every other week starting on Day 29</p>	40 mg every other week
Avsola [™] , Renflexis [™] , Inflectra [®] (infliximab)	<p><u>Initial dose:</u> 5 mg/kg IV at weeks 0, 2 and 6</p> <p><u>Maintenance dose:</u> 5 mg/kg IV every 8 weeks.</p> <p>Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response</p>	10 mg/kg every 8 weeks

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

*Off-label

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Patients who have or have had progressive multifocal leukoencephalopathy
 - Patients who have had a hypersensitivity reaction to Tysabri
- Boxed warning(s): progressive multifocal leukoencephalopathy

Appendix D: General Information

- Because of the risk of progressive multifocal leukoencephalopathy, Tysabri is only available through a REMS program called the TOUCH[®] Prescribing Program.
- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone[®], Glatopa[®]), interferon beta-1a (Avonex[®], Rebif[®]), interferon beta-1b (Betaseron[®], Extavia[®]), peginterferon beta-1a (Plegridy[®]), dimethyl fumarate (Tecfidera[®]), diroximel fumarate (Vumerity[®]), monomethyl fumarate (Bafiertam[™]), fingolimod (Gilenya[®]), teriflunomide (Aubagio[®]), alemtuzumab (Lemtrada[®]), mitoxantrone (Novantrone[®]), natalizumab (Tysabri[®]), ocrelizumab (Ocrevus[®]), cladribine (Mavenclad[®]), siponimod (Mayzent[®]), ozanimod (Zeposia[®]), and ofatumumab (Kesimpta[®]).
- The American Academy of Neurology 2018 MS guidelines recommend the use of Gilenya, Tysabri, and Lemtrada for patients with highly active MS. Definitions of highly active MS vary and can include measures of relapsing activity and MRI markers of disease activity, such as numbers of gadolinium-enhanced lesions.
- Of the disease-modifying therapies for MS that are FDA-labeled for CIS, only the interferon products, glatiramer, and Aubagio have demonstrated any efficacy in

decreasing the risk of conversion to MS compared to placebo. This is supported by the AAN 2018 MS guidelines.

- Definition of failure of MTX or DMARDs
 - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
 - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.

Appendix E: Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for Crohn’s disease:
 - Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
 - High-risk factors for intestinal complications may include:
 - Initial extensive ileal, ileocolonic, or proximal GI involvement
 - Initial extensive perianal/severe rectal disease
 - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
 - Deep ulcerations
 - Penetrating, stricturing or stenosis disease and/or phenotype
 - Intestinal obstruction or abscess

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Relapsing MS, CD	300 mg IV every 4 weeks In CD, discontinue in patients who have not experienced therapeutic benefit by 12 weeks of induction therapy and in patients that cannot discontinue chronic concomitant steroids within six months of starting therapy	300 mg/4 weeks

VI. Product Availability

Single-use vial: 300 mg/15 mL

VII. References

1. Tysabri Prescribing Information. Cambridge, MA: Biogen Inc; June 2020. Available at <http://www.tysabri.com>. Accessed February 8, 2021.
2. Lichtenstein GR, Loftus Jr. EV, Isaacs KI, Regueiro MD, Gerson LB, and Sands BE. ACG clinical guideline: management of Crohn’s disease in adults. Am J Gastroenterol. 2018; 113:481-517.
3. Sandborn WJ. Crohn’s Disease Evaluation and Treatment: Clinical Decision Tool. Gastroenterology 2014; 147: 702-705.

4. Bernell O, Lapidus A, Hellers G. Risk Factors for Surgery and Postoperative Recurrence in Crohn’s Disease. *Annals of Surgery*. 2000; 231(1): 38-45.
5. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis: report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology*. 2018; 90(17): 777-788. Full guideline available at: <https://www.aan.com/Guidelines/home/GetGuidelineContent/904>.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2323	Injection, natalizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted from CP.PHAR.259	04.01.22	04.22

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.

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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.

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