PHARMACY POLICY STATEMENT
Michigan Medicaid

DRUG NAME	Natalizumab (Tysabri, Tyruko)
BENEFIT TYPE	Medical
STATUS	Prior Authorization Required

Tysabri, approved by the FDA in 2004, is an integrin receptor antagonist indicated as monotherapy for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults and to induce and maintain clinical response and remission in adult patients with moderately to severely active Crohn's disease with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-α.
Tyruko, approved by the FDA in 2023, is the only approved biosimilar. It is indicated for the same indications as Tysbari.

Natalizumab (Tysabri, Tyruko) will be considered for coverage when the following criteria are met:

Multiple Sclerosis (MS)

For **initial** authorization:
1. Member must be at least 18 years of age; AND
2. Medication must be prescribed by, or in consultation with, a neurologist; AND
3. Member has a diagnosis of clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease; AND
4. Member has documentation of at least **ONE** of the following:
   a) Inadequate response to two or more drugs indicated for the treatment of MS
   b) Highly active disease (aggressive or rapidly evolving) in the expert opinion of the prescriber.
5. **Dosage allowed/Quantity limit:** 300 mg intravenous infusion every 4 weeks. Quantity limit: 1 vial per 28 days.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes must document positive clinical response such as improved disability, slowed progression of disability, or decreased frequency of relapses compared to baseline.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Crohn's Disease (CD)

For **initial** authorization:
1. Member must be at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has a documented diagnosis of moderately to severely active CD; AND

4. Member has had a documented trial and inadequate response, or intolerance to at least **ONE** of the following conventional therapies. Note: trial is not required if member is switching from another advanced therapy:
   a) Corticosteroid;
   b) 6-mercaptopurine, azathioprine or methotrexate; AND
5. Member has tried and failed an anti-TNF drug (e.g., Cimzia, Humira, Remicade) unless not tolerated or contraindicated. Note: trial is not required if member has multiple sclerosis and CD; AND
6. Medication is **NOT** being used in combination with immunosuppressants or TNF-alpha inhibitors.
7. **Dosage allowed/Quantity limit**: 300 mg intravenous infusion every 4 weeks. Quantity limit: 1 vial per 28 days.

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes have been provided showing improvement in signs and symptoms of CD such as mucosal healing, fewer flare-ups of symptoms, ability to taper off corticosteroid, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

HAP CareSource considers Natalizumab (Tysabri, Tyruko) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Tysabri created. Policy SRx-0041 archived. For diagnosis of CD: trial of Humira required. For RRMS and SPMS diagnoses trial of two formulary agents required. List of diagnoses considered not medically necessary was added.
12/06/2017	Age coverage expanded.
02/26/2019	Humira trial removed from criteria for CD.
11/23/2020	For CD: Changed the trial to only ask for 1 conventional therapy rather than 2. Also added a trial of an anti-TNF in accordance with package insert and guidelines. Changed initial auth to 3 months to observe benefit (must discontinue if no benefit after 3 months).
07/15/2022	Transferred to new template. MS: Updated and added references. Specified types of MS indicated. Added highly active disease option as alternative to trying 2 other drugs first. Specified that the JCV test should be negative. Added clinical criteria for renewal. CD: Added ability to taper off steroids as option to meet renewal criteria.
11/16/2023	Removed JCV antibody test requirement.
09/17/2025	Updated references CD: removed duration from conventional trials; replaced “biologic” with “advanced” in note when trial is not required
04/24/2026	Added Tyruko to policy. Updated policy name to Natalizumab (Tysabri, Tyruko).

References:

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2. Tyruko [prescribing information]. Sandoz Inc.; 2025.
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12. Feuerstein JD, Ho EY, Shmidt E, et al. AGA Clinical Practice Guidelines on the Medical Management of Moderate to Severe Luminal and Perianal Fistulizing Crohn's Disease. *Gastroenterology*. 2021;160(7):2496-2508. doi:10.1053/j.gastro.2021.04.022

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