Louisiana Medicaid
Natalizumab-sztn (Tyruko®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for natalizumab-sztn (Tyruko®).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy for Specific Diagnoses

Multiple Sclerosis

- The recipient has a diagnosis of multiple sclerosis; **AND**
- The recipient is 18 years of age or older on the date of the request; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a neurologist; **AND**
- **ONE** of the following applies:
    - The recipient has had a *treatment failure* with at least one preferred product that is indicated for treatment of multiple sclerosis (see Multiple Sclerosis Agents – Immunomodulatory Agents on PDL); **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product that is indicated for treatment of multiple sclerosis (see Multiple Sclerosis Agents – Immunomodulatory Agents on PDL); **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are indicated for treatment of multiple sclerosis (see Multiple Sclerosis Agents – Immunomodulatory Agents on PDL).

Crohn's Disease

- The recipient has a diagnosis of moderately to severely active Crohn's disease; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a gastroenterologist; **AND**
- **ONE** of the following applies:
    - The recipient has had a *treatment failure* with at least one preferred product that is indicated for treatment of Crohn's disease (see Pain Management – Cytokine and CAM Antagonists on PDL); **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product that is indicated for treatment of Crohn's disease (see Pain Management – Cytokine and CAM Antagonists on PDL); **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are indicated for treatment of Crohn's disease (see Pain Management – Cytokine and CAM Antagonists on PDL); **OR**

- There is *no preferred product that is appropriate to use for the condition* being treated (see Pain Management – Cytokine and CAM Antagonists on PDL)**.**

Approval Criteria for Continuation of Therapy for ALL Diagnoses

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy: 12 months

Reference

Tyruko (natalizumab-sztn) [package insert]. Princeton, NJ: Sandoz Inc; August 2023. https://tyruko-com.cms.sandoz.com/sites/default/files/2023-10/full_pi%20TYRUKO%2004OCT2023.pdf?_gl=1*1qqj67o*_gcl_au*OTk1NjAzNzgwLjE3NTk1MjQzMzM.

Revision / Date	Implementation Date
Policy created / October 2025	April 2026