Policy Number	**RX501.059**
Policy Effective Date	**11/01/2025**

Natalizumab and Associated Biosimilar(s)

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Related Policies (if applicable)
None

Disclaimer

Medical policies are a set of written guidelines that support current standards of practice. They are based on current generally accepted standards of and developed by nonprofit professional association(s) for the relevant clinical specialty, third-party entities that develop treatment criteria, or other federal or state governmental agencies. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and generally accepted standards of medical care. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For HCSC members residing in the state of Ohio, § 3923.60 requires any group or individual policy (Small, Mid-Market, Large Groups, Municipalities/Counties/Schools, State Employees, Fully-Insured, PPO, HMO, POS, EPO) that covers prescription drugs to provide for the coverage of any drug approved by the U. S. Food and Drug Administration (FDA) when it is prescribed for a use recognized as safe and effective for the treatment of a given indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature even if the FDA has not approved the drug for that indication. Medical literature support is only satisfied when safety and efficacy has been confirmed in two articles from major peer-reviewed professional medical journals that present data supporting the proposed off-label use or uses as generally safe and effective. Examples of accepted journals include, but are not limited to, Journal of

American Medical Association (JAMA), New England Journal of Medicine (NEJM), and Lancet. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. Evidence limited to case studies or case series is not sufficient to meet the standard of this criterion. Coverage is never required where the FDA has recognized a use to be contraindicated and coverage is not required for non-formulary drugs.

Coverage

Multiple Sclerosis

Tysabri® (natalizumab) and Tyruko® (natalizumab-sztn) **may be considered medically necessary** as monotherapy for the treatment of adult patients (18 years of age and older) with relapsing forms of multiple sclerosis (MS) when meeting **ALL** the following criteria:

- Medical record documentation with a diagnosis of a relapsing form of MS to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; AND
- Documentation of a magnetic resonance imaging (MRI) brain scan prior to initiating therapy.

Crohn Disease

Tysabri® (natalizumab) and Tyruko® (natalizumab-sztn) **may be considered medically necessary** for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn 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-alpha (TNF-a), **AND** when meeting **ALL** the following criteria:

- Documentation that the individual is not also receiving chronic immunosuppressant or immunomodulatory therapy (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate or concomitant inhibitors of TNF-α. **NOTE 1**: Aminosalicylates may be continued during treatment with Tysabri, steroids should be tapered off by month 6 of Tysabri).

NOTE 2: The Food and Drug Administration (FDA) recommends discontinuing Tysabri and Tyruko for CD in individuals who have not experienced therapeutic benefit by twelve weeks of induction therapy, and in patients who cannot discontinue chronic concomitant steroids within six months of starting therapy. Other than the initial six-month taper, prescribers should consider discontinuing natalizumab products for patients who require additional steroid use that exceeds three months in a calendar year to control their CD.

Other Indications

Tysabri® (natalizumab) and Tyruko® (natalizumab-sztn) **are considered experimental, investigational and/or unproven** for all other non-FDA approved indications.

Policy Guidelines

None.

Description

Natalizumab is a monoclonal antibody bioengineered in the laboratory and designed to hamper the movement of potentially damaging immune cells from the bloodstream, across the "blood brain barrier," and into the brain and spinal cord. (3) The monoclonal antibody was first approved by the U.S. Food and Drug Administration (FDA) for the treatment of relapsing forms of multiple sclerosis (MS) and later withdrawn by the manufacturer after three patients developed progressive multifocal leukoencephalopathy (PML) during clinical trials. PML is a rare and frequently fatal demyelinating disease of the central nervous system that primarily affects immunocompromised patients. The FDA is informing the public through a safety communication that testing positive for anti-JC virus (JCV) antibodies has been identified as a risk factor for PML. Although JCV is a common virus that is generally harmless and does not cause symptoms in people whose immune systems function normally, it can cause PML in people with weakened immune systems. Natalizumab was re-approved by the FDA and is indicated for the treatment of patients with relapsing forms of MS to reduce the frequency of clinical exacerbations and is now also approved for the treatment of moderate-to-severe Crohn disease (CD). (4)

Multiple Sclerosis
Multiple sclerosis is a chronic, often disabling disease of the brain and spinal cord. According to a study funded by the National MS Society, nearly 1 million people are living with MS in the United States. There are currently four basic MS disease courses (also called types or phenotypes). They were defined by the International Advisory Committee on Clinical Trials of MS in 1996: clinically isolated syndrome, relapsing remitting, secondary progressive and primary progressive. Clinically isolated syndrome refers to a first episode of neurologic symptoms. Common symptoms include bladder dysfunction, visual disturbances and difficulty with coordination. Secondary progressive MS can be further characterized at different points in time as either active (with relapses and/or evidence of new MRI activity) or not active, as well as with progression (evidence of disease worsening on an objective measure of change over time, with or without relapses) or with or without progression. (6, 7) The most common form of MS at the time of initial diagnosis is a relapsing-remitting form (RRMS), in which acute symptoms or worsening of neurologic function (referred to as "relapses", "attacks", or "exacerbations") occur intermittently. (8)

Prior to receiving treatment for MS with natalizumab products, an MRI brain scan must be obtained for each patient to aid in the differentiation of potential MS symptoms from PML. To enable early identification of potential cases, periodic follow-ups are required at three and six months after the initial infusion and then every six months thereafter. (1)

NOTE 3: The prescriber and the patient must be enrolled in and meet all the criteria of the MS TOUCH Prescribing Program for Tysabri and the MS TYRUKO REMS Program for Tyruko.

Crohn Disease
Crohn disease is a chronic, inflammatory bowel disease that affects both men and women. There is no cure. Crohn disease can cause diarrhea, fever, rectal bleeding, malnutrition, narrowing of the intestinal tract, obstructions, abscesses, cramping, and abdominal pain. The disease also can lead to abnormal connections (fistulas) leading from the intestine to the skin or internal organs. Its cause is unknown. There are more than one million people worldwide with CD. (9)

In CD patients, a baseline brain MRI may be helpful to distinguish pre-existent lesions from newly developed lesions, but brain lesions at baseline that could cause diagnostic difficulty while on natalizumab products are uncommon.

NOTE 4: The prescriber and the patient must be enrolled in and meet all the criteria of the CD TOUCH Prescribing Program for Tysabri and the CD TYRUKO REMS Program for Tyruko.

Regulatory Status
Tysabri® (natalizumab) was FDA-approved November 2004 and later withdrawn by the manufacturer. Tysabri® was re-approved by the FDA in June 2006 for the treatment of patients with relapsing forms of MS to reduce the frequency of clinical exacerbations. (1) In January 2008, the FDA approved Tysabri for the treatment of moderate-to-severe CD in patients with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies. In August 2019, the FDA revised the prescribing information to clarify that relapsing forms of multiple sclerosis includes clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. (1) In August 2023 Tyruko® (natalizumab-sztn) was approved by the FDA. Tyruko® is biosimilar to Tysabri®. (2) Tyruko was FDA-approved for all indications as the reference medicine, Tysabri.

Both Tysabri® and Tyruko® are given intravenously every four weeks and are only available to prescribing physicians and patients for Tysabri through a distribution program known as TOUCH® administered by Biogen Idec, Inc and for Tyruko a restricted distribution program called the TYRUKO REMS Program. The TOUCH® and the TYRUKO REMS Programs are distribution programs designed to assess the risk of PML associated with natalizumab products and to minimize the risk of PML, minimize death and disability due to PML, and promote informed risk-benefit decisions regarding the use of the treatment. The risks of the treatment are addressed through the programs, along with education of prescribers, pharmacists, infusion center staff, and patients about potential PML infection associated with the treatment. Safety and efficacy of natalizumab products beyond two years are not known. (1, 2, 5)

Rationale

This policy is based on the U.S. Food and Drug Administration (FDA) labeled indications for Tysabri® (natalizumab) and Tyruko® (natalizumab-sztn).

Multiple Sclerosis (MS) (1, 2)

Natalizumab was evaluated in two randomized, double-blind, placebo-controlled trials in patients with multiple sclerosis. Both studies enrolled patients who experienced at least one clinical relapse during the prior year and had a Kurtzke Expanded Disability Status Scale (EDSS) score between 0 and 5.0. Results for each study are shown in Table 1 and Table 2. Median time on study drug was 120 weeks in each study. In both studies, neurological evaluations were performed every 12 weeks and at times of suspected relapse. Magnetic resonance imaging evaluations for T1-weighted gadolinium (Gd)-enhancing lesions and T2-hyperintense lesions were performed annually.

Study MS1 enrolled patients who had not received any interferon-beta or glatiramer acetate for at least the previous 6 months; approximately 94% had never been treated with these agents. Median age was 37, with a median disease duration of 5 years. Patients were randomized in a 2:1 ratio to receive natalizumab 300 mg intravenous infusion (n=627) or placebo (n=315) every 4 weeks for up to 28 months (30 infusions).

Study MS2 enrolled patients who had experienced one or more relapses while on treatment with AVONEX® (Interferon beta-1a) 30 mcg intramuscularly (IM) once weekly during the year prior to study entry. Median age was 39, with a median disease duration of 7 years. Patients were evenly randomized to receive natalizumab 300 mg (n=589) or placebo (n=582) every 4 weeks for up to 28 months (30 infusions). All patients continued to receive AVONEX® 30 mcg IM once weekly. The efficacy of natalizumab alone was not compared with the efficacy of natalizumab plus AVONEX®.

The primary endpoint at 2 years was time to onset of sustained increase in disability, defined as an increase of at least 1 point on the EDSS from baseline EDSS ≥1.0 that was sustained for 12 weeks, or at least a 1.5 point increase on the EDSS from baseline EDSS=0 that was sustained for 12 weeks. Time to onset of sustained increase in disability was longer in natalizumab-treated patients than in placebo-treated patients in Studies MS1 (Figure 1) and MS2. The proportion of patients with increased disability and the annualized relapse rate were also lower in natalizumab-treated patients than in placebo-treated patients in Studies MS1 and MS2 (Table 1 and Table 2).

Table 1: Clinical and MRI Endpoints in Study MS1 (Monotherapy Study) at 2 Years

	Natalizumab (n=627)	**Placebo (n=315)**
CLINICAL ENDPOINTS		
Percentage with sustained increase in disability	17%	29%
Relative Risk Reduction	42% (95% CI 23%, 57%)	
Annualized relapse rate	0.22	0.67
Relative reduction (percentage)	67%	
Percentage of patients remaining relapse-free	67%	41%

MRI ENDPOINTS		
New or newly enlarging T2-hyperintense lesions		
Median	0.0	5.0
Percentage of patients with*:		
0 lesions	57%	15%
1 lesion	17%	10%
2 lesions	8%	8%
3 or more lesions	18%	68%
Gd-enhancing lesions		
Median	0.0	0.0
Percentage of patients with:		
0 lesions	97%	72%
1 lesion	2%	12%
2 or more lesions	1%	16%

All analyses were intent-to-treat. For each endpoint, $p<0.001$. Determination of p-values: Increase in disability by Cox proportional hazards model adjusted for baseline EDSS and age; relapse rate by Poisson regression adjusting for baseline relapse rate, EDSS, presence of Gd-enhancing lesions, age; percentage relapse-free by logistic regression adjusting for baseline relapse rate; and lesion number by ordinal logistic regression adjusting for baseline lesion number.
Annualized relapse rate is calculated as the number of relapses for each subject divided by the number of years followed in the study for that subject. The value reported is the mean across all subjects.
*Values do not total 100% due to rounding.

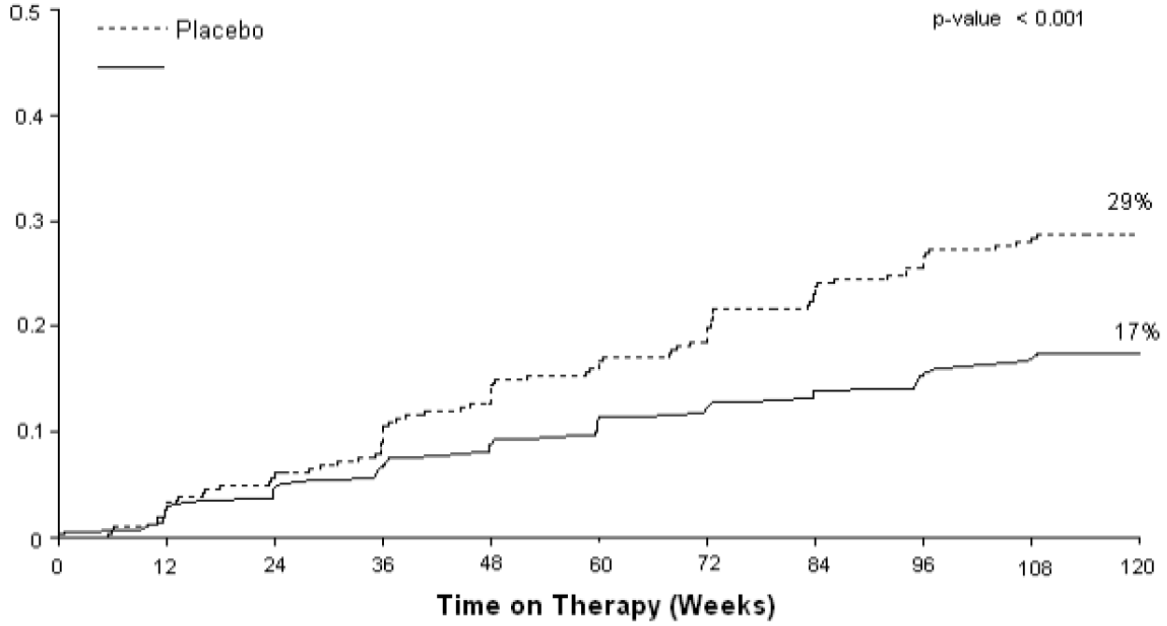
Table 2: Clinical and MRI Endpoints in Study MS2 (Add-On Study) at 2 Years

	Natalizumab plus AVONEX® (n=589)	**Placebo plus AVONEX® (n=582)**
CLINICAL ENDPOINTS		
Percentage with sustained increase in disability	23%	29%
Relative Risk Reduction	24% (95% CI 4%, 39%)	
Annualized relapse rate	0.33	0.75
Relative reduction (percentage)	56%	
Percentage of patients remaining relapse-free	54%	32%
MRI ENDPOINTS		
New or newly enlarging T2-hyperintense lesions		
Median	0.0	3.0
Percentage of patients with*:		
0 lesions	67%	30%
1 lesion	13%	9%
2 lesions	7%	10%
3 or more lesions	14%	50%
Gd-enhancing lesions		
Median	0.0	0.0
Percentage of patients with:		

0 lesions	96%	75%
1 lesion	2%	12%
2 or more lesions	1%	14%

All analyses were intent-to-treat. For disability accumulation p=0.024, for all other endpoints, p<0.001. Determination of p-values: Increase in disability by Cox proportional hazards model adjusted for baseline EDSS; relapse rate by Poisson regression adjusting for baseline relapse rate, EDSS, presence of Gd-enhancing lesions, age; percentage relapse-free by logistic regression adjusting for baseline relapse rate; and lesion number by ordinal logistic regression adjusting for baseline lesion number.
Annualized relapse rate is calculated as the number of relapses for each subject divided by the number of years followed in the study for that subject. The value reported is the mean across all subjects.
*Values do not total 100% due to rounding.

Figure 1: Time to Increase in Disability Sustained for 12 Weeks in Study MS1



Crohn Disease (1, 2)

The safety and efficacy of natalizumab were evaluated in three randomized, double-blind, placebo-controlled clinical trials in 1414 adult patients with moderately to severely active Crohn's disease (Crohn's Disease Activity Index [CDAI] ≥220 and ≤450). Concomitant inhibitors of TNF-α were not permitted. Concomitant stable doses of aminosalicylates, corticosteroids, and/or immunosuppressants (e.g., 6-mercatopurine, azathioprine, or methotrexate) were permitted, and 89% of patients continued to receive at least one of these medications. Although permitted in the clinical trials, combination therapy with immunosuppressants is not recommended. Overall, approximately two-thirds of patients were not taking concomitant immunosuppressants, and approximately one-third of patients were taking neither concomitant immunosuppressants nor concomitant corticosteroids.

Induction of clinical response (defined as ≥70-point decrease in CDAI from baseline) was evaluated in two studies. In Study CD1, 896 patients were randomized 4:1 to receive three monthly infusions of either 300 mg natalizumab or placebo. Clinical results were assessed at

Week 10, and patients with incomplete information were considered as not having a clinical response. At Week 10, 56% of the 717 patients receiving natalizumab were in response compared to 49% of the 179 patients receiving placebo (treatment effect: 7%; 95% confidence interval (CI): [-1%, 16%]; p=0.067). In a post hoc analysis of the subset of 653 patients with elevated baseline C-reactive protein (CRP), indicative of active inflammation, 57% of natalizumab patients were in response compared to 45% of those receiving placebo (treatment effect: 12%; 95% CI: [3%, 22%]; nominal p=0.01).

In the second induction trial, Study CD2, only patients with elevated serum C-reactive Protein (CRP) were studied. A total of 509 patients were randomized 1:1 to receive three monthly infusions of either 300 mg natalizumab or placebo. In Study CD2, in contrast to Study CD1, clinical response and clinical remission (defined as CDAI score <150) were required to be met at both Weeks 8 and 12, rather than at a single time-point; patients with incomplete information were considered as not having a response (Table 3).

Table 3: Induction of Clinical Response and Remission in Study CD2

	Natalizumab (n=259)	**Placebo (n=250)**	**Treatment Difference (95% CI)**
Clinical Response at:			
Week 8	56%	40%	16% (8%, 26%)
Week 12	60%	44%	16% (7%, 25%)
Both Weeks 8 & 12*	48%	32%	16% (7%, 24%)
Clinical Remission at:			
Week 8	32%	21%	11% (3%, 19%)
Week 12	37%	25%	12% (4%, 21%)
Both Weeks 8 & 12*	26%	16%	10% (3%, 18%)

CI: Confidence interval.
* p <0.005
Response is defined as a ≥70-point reduction in CDAI score from baseline.
Remission is defined as CDAI <150.

Maintenance therapy was evaluated in Study CD3. In this study, 331 patients from Study CD1 that had had a clinical response to natalizumab at both Weeks 10 and 12 were re-randomized 1:1 to treatment with continuing monthly infusions of either 300 mg natalizumab or placebo.

Maintenance of response was assessed by the proportion of patients who did not lose clinical response at any study visit for an additional 6 and 12 months of treatment (i.e., Month 9 and Month 15 after initial treatment with natalizumab). The study also assessed the proportion of patients who did not lose clinical remission at any study visit within the subset of those who were in remission at study entry. Requiring maintenance of response or remission at each visit, as opposed to just at Month 9 or Month 15, may result in lower proportions meeting endpoint criteria, and may make a comparison of these results with those of other products used to treat Crohn's disease misleading (Table 4).

Table 4: Maintenance of Clinical Response and Remission in Study CD3

	Natalizumab	Placebo	Treatment Difference (95% CI)
Clinical Response through:	**(n=164)**	**(n=167)**	
Month 9*	61%	29%	32% (21%, 43%)
Month 15	54%	20%	34% (23%, 44%)
Clinical Remission through:	**(n=128†)**	**(n=118†)**	
Month 9*	45%	26%	19% (6%, 31%)
Month 15	40%	15%	25% (13%, 36%)

CI: Confidence interval.

* $p<0.0005$

† Number of patients included for analysis of "through" Month 9 and Month 15 includes only those in remission upon entry into Study CD3.

Response is defined as CDAI <220 and a ≥70-point reduction in CDAI score compared to Baseline from Study CD1.

Remission is defined as CDAI <150.

For subgroups in study CD3 defined by prior use of, or by inadequate response to prior therapies (i.e., corticosteroids, immunosuppressants, and inhibitors of TNF-α), the treatment effect was generally similar to that seen in the whole study population. In the subgroup of patients that were taking neither concomitant immunosuppressants nor concomitant corticosteroids, the treatment effect was generally similar to that seen in the whole study population. Patients with inadequate response to inhibitors of TNF-α appeared to have lower maintenance of clinical response and lower maintenance of clinical remission in both the treatment and placebo groups. For patients in study CD3 with an inadequate response to prior treatment with inhibitors of TNF-α, maintenance of clinical response through Month 9 was seen in 52% of those randomized to natalizumab, and maintenance of clinical remission through Month 9 was seen in 30%.

Given the requirement to discontinue chronic steroids it is important to note that in the subgroup of patients (n=65) who were receiving corticosteroid medication at baseline, responded to natalizumab in Study CD1, and were re-randomized to natalizumab in Study CD3, approximately two-thirds were able to discontinue steroids within 10 weeks of initiating a steroid taper.

Summary of Evidence

Based on the clinical studies provided to the U.S. Food and Drug Administration (FDA), natalizumab products (Tysabri and Tyruko) may be considered medically necessary as monotherapy for the treatment of adult patients (18 years of age and older) with relapsing forms of multiple sclerosis (MS) and for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn 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-alpha when the criteria is

met. Natalizumab products (Tysabri and Tyruko) are considered experimental, investigational and/or unproven for all other non-FDA approved indications.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	J2323, Q5134

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

U.S. Food and Drug Administration Labels:

1. FDA – U. S. Department of Health and Human Services - Tysabri- Approval Labeling (3/2025). Available at <https://www.accessdata.fda.gov> (accessed June 25, 2025).
2. U.S. Food and Drug Administration (FDA). Drugs@FDA: FDA-Approved Drugs. Tyruko- Highlights of Prescribing Information. 8/2023. Available at <https://www.accessdata.fda.gov> (accessed June 25, 2025).

Other:

3. National Multiple Sclerosis Society. Treatment MS/Medications - Tysabri (2025). Available at <https://www.nationalmssociety.org> (accessed June 25, 2025).
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6. National Multiple Sclerosis Society – Types of MS. 2025. Available at <https://www.nationalmssociety.org> (accessed June 25, 2025).
7. National Multiple Sclerosis Society – How Many People Live with MS? 2025. Available at <https://www.nationalmssociety.org> (accessed June 25, 2025).
8. National Multiple Sclerosis Society – Relapsing-Remitting Multiple Sclerosis (RRMS). 2025. Available at <https://www.nationalmssociety.org> (accessed June 25, 2025).
9. FDA – FDA News – FDA Approved Tysabri to Treat Moderate-to-Severe Crohn's Disease. 2008. Available at <https://www.fda.gov> (accessed June 25, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
11/01/2025	Document updated with literature review. Revised coverage to be in alignment with the current FDA labels for Tysabri (natalizumab) and biosimilar Tyruko® (natalizumab-sztn). No new references added; others updated.
07/15/2024	Document updated with literature review. The following change was made to Coverage: Revised coverage statements to include the biosimilar Tyruko® (natalizumab-sztn). Added references 1, 2, 5, 8; some updated and others removed. Title changed from Natalizumab.
05/01/2023	Reviewed. No changes.
09/15/2022	Document updated with literature review. The following change was made to Coverage: Will not receive natalizumab concurrently with other disease modifying therapies used to treat multiple sclerosis (e.g., alemtuzumab, immune globulin, ocrelizumab, rituximab) was added to the medically necessary statement for the treatment of multiple sclerosis. Reference 5 added, and others updated.
03/15/2021	Reviewed. No changes.
04/01/2020	Document updated with literature review. The following changes were made to Coverage: 1) Medical record documentation (by a neurologist) with a diagnosis of a relapsing form of MS was expanded to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, and 2) NOTE 1: Relapsing forms of MS include relapsing-remitting MS (RRMS), secondary progressive MS (SPMS) with relapses, and progressive-relapsing MS (PRMS) was removed. References 4, 5, and 11 were added.
12/15/2018	Document updated with literature review. Coverage unchanged. References updated but no new references added.
08/15/2017	Reviewed. No changes.
07/15/2016	Document updated with literature review. Coverage unchanged

10/01/2015	Reviewed. No changes.
04/15/2014	Document updated with literature review. Coverage statement for Tysabri, specific to multiple sclerosis, was modified to remove statement requiring that patients must have an inadequate response to, or are unable to tolerate, alternate MS therapies.
12/15/2013	Document updated with literature review. Coverage unchanged.
01/01/2011	Document updated with literature review. Coverage unchanged.
04/15/2008	Coverage revised
12/15/2006	New Medical Document