TYSABRI (NATALIZUMAB) [PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 7/30/20)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Medication requested: Tysabri (natalizumab) 300 mg/15 ml	Quantity: vials	Refills:
Directions: ☐ 300 mg SQ every 4 weeks ☐ other: _____		Dx code *(required)*:

Diagnosis: ☐ relapsing multiple sclerosis – *Submit documentation of diagnosis and disease pattern.*
☐ moderately to severely active Crohn's disease with inflammation – *Submit documentation of diagnosis and disease severity.*
☐ other: _____ – *Submit documentation supporting the use of Tysabri for the patient's condition.*

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication, if applicable):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) INFORMATION (if applicable):

Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's Office ☐ Hospital Outpatient Facility		
Facility name:	Facility NPI:	
J-code:	Number of units:	Date of service (MM/DD/YYYY):

INITIAL REQUESTS

1. Does the patient have results of baseline testing for anti-JC virus antibodies? ☐ Yes ☐ No
   Submit documentation.
2. <u>For the treatment of MS</u>, did the patient have a baseline MRI scan of the brain prior to initiating Tysabri? ☐ Yes ☐ No
   Submit documentation.
3. <u>For the treatment of Crohn's disease</u>, does the patient have a history of a 3-month trial and failure of, or contraindication or intolerance to, the following medications? Check all that apply.
   ☐ aminosalicylates (e.g., mesalamine, sulfasalazine) ☐ immune modulators (e.g., azathioprine, methotrexate, 6-mercaptopurine) ☐ TNF-a inhibitors (e.g., Humira)
   ☐ Yes – List medications being used:
   ☐ No

RATIONALE FOR HOSPITAL OUTPATIENT FACILITY TREATMENT SETTING (if applicable):

☐ Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions

☐ Documentation that the member is medically unstable for the safe and effective administration of the prescribed medication at an alternative site of care as a result of one of the following:
- ☐ Complex medical condition, status, or therapy requires services beyond the capabilities of an office or home infusion setting (clinical instability or a complex regimen that requires frequent clinical assessment or monitoring, which would be beyond the capabilities of an office or home infusion setting)
- ☐ Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less intensive site of care (unstable fluid status associated with heart failure or advanced [stage 4 or 5] renal failure)

RENEWAL REQUESTS

1. Did the patient experience disease improvement or stabilization since starting Tysabri? ☐ Yes ☐ No
   Submit documentation of response to therapy.
2. <u>If baseline testing for anti-JC virus antibodies was negative</u>, does the patient have results of repeat testing since starting Tysabri? ☐ Yes ☐ No
   Submit documentation.
3. <u>For the treatment of Crohn's disease</u>, was the patient able to discontinue use of steroid medications within 6 months of starting Tysabri? ☐ Yes ☐ No
   Submit documentation.
4. <u>For the treatment of Crohn's disease</u>, did the patient require steroids to control symptoms for more than 3 months in the past year? ☐ Yes ☐ No
   Submit documentation.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: