

TYSABRI (NATALIZUMAB) [PREFERRED] PRIOR AUTHORIZATION FORM



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

(form effective 1/5/2021)

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

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request	<input type="checkbox"/> 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: <input type="checkbox"/> 300 mg SQ every 4 weeks <input type="checkbox"/> other: _____			Dx code (<i>required</i>): _____
Diagnosis: <input type="checkbox"/> relapsing multiple sclerosis – <i>Submit documentation of diagnosis and disease pattern.</i> <input type="checkbox"/> moderately to severely active Crohn's disease with inflammation – <i>Submit documentation of diagnosis and disease severity.</i> <input type="checkbox"/> other: _____ – <i>Submit documentation supporting the use of Tysabri for the patient's condition.</i>			

PHARMACY INFORMATION

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

Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.		

HCPSC (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) INFORMATION

 (if applicable):

Treatment setting: <input type="checkbox"/> Infusion Center <input type="checkbox"/> Home <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital Outpatient Facility	Facility name:	Facility NPI:
J-code:	Number of units:	Date of service (MM/DD/YYYY):

INITIAL REQUESTS

- Is Tysabri (natalizumab) being prescribed by or in consultation with an appropriate specialist?
 Yes, list specialty: _____
 No
- Does the patient have a contraindication to Tysabri? Yes No
- Is patient receiving chronic immunosuppressant or immunomodulator therapy?
 Yes, list medications: _____
 No
- For the treatment of Crohn's disease, Does at least one of the following apply to the patient?
 moderate to severe Crohn's disease and one of the following:
 failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
 failed to maintain remission or has a contraindication or intolerance to immunomodulators
 has one or more high-risk or poor prognostic features
 has achieved remission with the requested medication and will be using the requested medication as maintenance therapy to maintain remission
- For the treatment of Crohn's disease, Does at least one of the following apply to the patient?
 history of trial and failure of at least one tumor necrosis factor (TNF) inhibitor; list medications tried:

 contraindication or intolerance to TNF inhibitors; provide explanation:

 current history (within the past 90 days) of being prescribed Tysabri

RATIONALE FOR HOSPITAL OUTPATIENT FACILITY TREATMENT SETTING

 (if applicable):

<input type="checkbox"/> Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions
<input type="checkbox"/> 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: <input type="checkbox"/> 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)
<input type="checkbox"/> 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)
<input type="checkbox"/> Clinically significant physical or cognitive impairment that precludes safe and effective treatment in an outpatient or home infusion setting (physical disability or disruptive or uncooperative behavior)
<input type="checkbox"/> Difficulty establishing and maintaining reliable vascular access

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RENEWAL REQUESTS

1. Did the patient experience disease improvement or stabilization since starting Tysabri? Yes No
Submit documentation of response to therapy.
2. For the treatment of Crohn's disease, was the patient able to discontinue use of steroid medications within 6 months of starting Tysabri? Yes No
Submit documentation.
3. For the treatment of Crohn's disease, 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:

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