FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Tysabri® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Crohn's disease (CD)

❑ Multiple sclerosis (MS)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

For Crohn's disease, answer the following:

Does the patient have moderate to severe Crohn's disease (CD)? ❑ **Yes** ❑ **No**

Does the patient's CD have evidence of inflammation (e.g., elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes)? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (6-MP [Purinethol])
- ❑ Aminosalicylates (e.g., sulfasalazine, mesalamine, olsalazine)
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids
- ❑ Methotrexate

Has the patient had a trial and failure, contraindication, or intolerance to a tumor necrosis factor (TNF)-inhibitor (e.g., Cimzia [certolizumab pegol], Humira [adalimumab], Remicade [infliximab])? ❑ **Yes** ❑ **No**

Select if the patient will be using Tysabri in combination with the following:

- ❑ Immunosuppressant (e.g., 6-MP, azathioprine, cyclosporine, or methotrexate)
- ❑ TNF-inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab], or Remicade [infliximab])

Reauthorization:

Is there documentation the patient has had a positive clinical response (e.g., improved disease activity index) to Tysabri therapy? ❑ **Yes** ❑ **No**

Select if the patient will be using Tysabri in combination with the following:

- ❑ Immunosuppressant (e.g., 6-MP, azathioprine, cyclosporine, or methotrexate)
- ❑ TNF-inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab], or Remicade [infliximab])

For multiple sclerosis, answer the following:

Does the patient have relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? ❑ **Yes** ❑ **No**

< continued on the next page >

Tysabri® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

< continued from the previous page >

Select if the patient has had a trial and failure or intolerance to the following disease-modifying therapies for MS:

- ❑ Aubagio (teriflunomide)
- ❑ Avonex (interferon beta-1a)
- ❑ Betaseron (interferon beta-1b)
- ❑ Copaxone/Glatopa (glatiramer acetate)
- ❑ Extavia (interferon beta-1b)
- ❑ Gilenya (fingolimod)
- ❑ Lemtrada (alemtuzumab)
- ❑ Mavenclad (cladribine)
- ❑ Mayzent (siponimod)
- ❑ Ocrevus (ocrelizumab)
- ❑ Plegridy (peginterferon beta-1a)
- ❑ Rebif (interferon beta-1a)
- ❑ Tecfidera (dimethyl fumarate)
- ❑ Zinbryta (daclizumab)

Is the patient **NOT** a candidate for any of the drugs listed above as prerequisites due to the severity of their MS? ❑ **Yes** ❑ **No**

Is this request for a continuation of prior Tysabri therapy? ❑ **Yes** ❑ **No**

Will Tysabri be used in combination with another disease-modifying therapy for MS? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.