TYSABRI (NATALIZUMAB) [PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 1/3/2022)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

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. Is Tysabri (natalizumab) being prescribed by or in consultation with an appropriate specialist?
   ☐ Yes, list specialty:_____
   ☐ No
2. Is patient receiving chronic immunosuppressant or immunomodulator therapy?
   ☐ Yes, list medications:_____
   ☐ No
3. <u>For the treatment of Crohn's disease</u>, 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
4. <u>For the treatment of Crohn's disease</u>, select all that apply to the patient.
   ☐ history of trial and failure of at least one tumor necrosis factor (TNF) inhibitor OR contraindication or intolerance to TNF inhibitors; list medications tried OR provide explanation for contraindication/intolerance:_____
   ☐ history of therapeutic failure, contraindication, or intolerance to ustekinumab (Stelara)
   ☐ history of therapeutic failure, contraindication, or intolerance to vedolizumab (Entyvio)
   ☐ current history (within the past 90 days) of being prescribed Tysabri

RENEWAL REQUESTS

1. <u>For the treatment of multiple sclerosis</u>, did the patient experience disease improvement or stabilization since starting Tysabri? ☐ Yes ☐ No
   Submit documentation of response to therapy.
2. <u>For the treatment of Crohn's disease</u>, select all that apply to the patient.
   ☐ experienced therapeutic benefit within 3 months of starting therapy
   ☐ was able to discontinue concomitant corticosteroid use within 6 months of starting therapy
   ☐ did not require additional steroid use for more than 3 months in a calendar year

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: