

TYSABRI (NATALIZUMAB) [PREFERRED]
PRIOR AUTHORIZATION FORM
(form effective 1/3/2022)



Keystone First
Community HealthChoices

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

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.	

HCPCS (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
- 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**, 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

- For the treatment of multiple sclerosis**, did the patient experience disease improvement or stabilization since starting Tysabri? Yes No
Submit documentation of response to therapy.
- For the treatment of Crohn's disease**, 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:
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