

Pharmacy PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Tysabri[®] (natalizumab)

 URGENT (life threatening)

 Non-Urgent (standard review)

 A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 Provider Signature

 Date

PRODUCT INFORMATION

 Tysabri injection 300 mg/15 mL

Dose: _____

Start Date: _____

BILLING INFORMATION

Place of administration:

- Self-administered
 Provider's Office
 Outpatient Infusion Center
 Center Name: _____
 Home Infusion
 Agency Name: _____

Billing Options:

- Physician buy and bill (J2323)
 Preferred Specialty Vendor
 Other: _____

Request:

- New – Complete Section A
 Continuation – Complete Section B

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Tysabri® (natalizumab) requires the following information to certify:

Patient must have met the following requirements:

- One of the following diagnoses with applicable step therapy requirements:
 - relapsing-remitting form of multiple sclerosis with a documented therapeutic trial and clinical failure with Copaxone and Rebif
 - moderately to severe active form of Crohn's disease with a documented therapeutic trial and clinical failure with Humira and Remicade
- Age 18 years or older

For continuation, patient must have met the following requirements:

- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, as determined by the prescribing physician

SECTION A – NEW THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Tysabri® (natalizumab) requires the following information to certify:

A. What is the patient's diagnosis?

- a. Relapsing-remitting multiple sclerosis ICD code: _____
- i. Which of the following medications has the patient had a documented therapeutic trial and clinical failure with (both required)?
- Copaxone Date of trial: _____
Expanded Disability Status Scale (EDSS) at initiation of therapy: _____
Current EDSS: _____
Number of exacerbations per year at initiation of therapy: _____
Number of exacerbations per year on therapy: _____
- Rebif Date of trial: _____
Expanded Disability Status Scale (EDSS) at initiation of therapy: _____
Current EDSS: _____
- b. Moderately to severe active form of Crohn's disease ICD code: _____
- i. Which of the following medications has the patient had a documented therapeutic trial and clinical failure with (both required)?
- Humira Date of trial: _____
 Remicade (*requires previous trial of Humira*)
Date of trial: _____
- c. Other: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

SECTION B – CONTINUATION

to be completed for patient's in which Tysabri[®] (natalizumab) was previously authorized by Priority Health

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Tysabri[®] (natalizumab) requires the following information to certify:

A. What is the patient's diagnosis?

- a. relapsing-remitting multiple sclerosis
b. moderately to severely active Crohn's disease
c. Other: _____

Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. Select which of the following apply (all must be met for continuation of therapy):

- The patient is compliant in taking the medication as scheduled
 The patient tolerated the medication
 The patient did not experience any severe adverse reactions while taking the medication
 The patient has responded to treatment, as determined by the prescribing physician

DURATION OF THERAPY**Note:**

- The safety and efficacy of treatment with Tysabri beyond two years is not known.
- The safety and efficacy in patients with chronic progressive multiple sclerosis have not been established.

WARNING: PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY

See full prescribing information for complete boxed warning

- **TYSABRI increases the risk of progressive multifocal leukoencephalopathy (PML), an opportunistic viral infection of the brain that usually leads to death or severe disability**
- **Monitor patients, and withhold TYSABRI immediately at the first sign or symptom suggestive of PML**
- **TYSABRI is available only through a special restricted distribution program called the TOUCH[®] Prescribing Program and must be administered only to patients enrolled in this program**

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX