PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Tysabri® (natalizumab)

Member

Last Name: ____________________ First Name: ____________________
ID #: ____________________ DOB: ____________ Gender: ____________
Primary Care Physician: ____________________

Requesting Provider: ____________________ Prov. Phone: ____________ Prov. Fax: ____________
Provider Address: ____
Provider NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: ____________

Product and Billing Information

Drug product: ☐ Tysabri

Start date (or date of next dose): ____________
Date of last dose (if applicable): ____________
Dosing frequency: ____________

Place of administration:
☐ Patient to fill at pharmacy
☐ Physician's office
☐ Outpatient infusion
Facility: ____________ NPI:____________ Fax:____________
☐ Home infusion
Facility: ____________ NPI:____________ Fax:____________

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:____________ NPI:____________ Fax:____________

ICD-10 Diagnosis code(s): ____________

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Diagnosis of multiple sclerosis
2. Diagnosis of Crohn's disease with a documented therapeutic trial of conventional therapies (e.g. oral corticosteroids, budesonide, mesalamine, olsalazine, sulfasalazine), and also with Humira or Remicade

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2012
Last reviewed 03/2019

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Multiple sclerosis
☐ Crohn's disease
☐ Other – the patient's condition is: ____________________

B. For patients with Crohn's disease, provide a history of previous treatment therapy (at least one drug from each section required):

At least one of the following:

☐ Oral corticosteroids (e.g. betamethasone, dexamethasone, hydrocortisone, methylprednisolone, prednisolone, prednisone)
☐ Budesonide (Entocort EC)
☐ Mesalamine
☐ Olsalazine (Dipentum)
☐ Sulfasalazine (Azulfidine, Sulfazine)
☐ Other: ____________________
☐ Other: ____________________

At least one of the following:

☐ Humira
☐ Remicade

PriorityMedicare 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.

WPS Medicare L32013

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Tysabri likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: ____________________

If the patient is currently using Tysabri, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: ____________________

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