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

☐ New request ☐ Continuation request - **Original therapy start date**: _____

Drug product:
☐ Drug Name and Strength
☐ Drug Name and Strength
☐ Drug Name and Strength

Date of last dose (if applicable): _____
Date of next dose (if applicable): _____
Dose:_____ **Dose Frequency**:_____
Number of doses/cycles/duration requested: _____

Patient Dosing Information:
Height:_____**Weight:**_____**BSA:**_____

ICD-10 Diagnosis code(s): _____

HCPCS Code: _____

Place of administration:
☐ Self-administration
☐ 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:_____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2019
Last reviewed 03/2019

Prior authorization criteria

Before this drug is covered, the patient must meet the following:

1. **Must be used for a medically accepted indication*.**

*Medically accepted indication

This drug is only covered under Medicare Part B 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 references, taking into consideration the major drug compendia (e.g. American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor) , authoritative medical literature, and/or accepted standards of medical practice.

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

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

Are you asking for an exception to the above list of diagnoses?

☐ Yes. ***Rationale for exception*:** _____
☐ No

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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