Tysabri

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital (22)
- ❑ Off Campus Outpatient Hospital (19)
- ❑ Home (12), *skip to Criteria Questions*
- ❑ Office (11), *skip to Criteria Questions*
- ❑ Ambulatory Surgical Center (24), *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. 1. Has the patient been diagnosed with any of the following?
- ❑ Moderately to severely active Crohn's disease (CD)
- ❑ Relapsing forms of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)
- ❑ Clinically isolated syndrome
- ❑ Other ___

2. What is the ICD-10 code? ____

3. What is the prescribed dose and frequency?____mg every_____weeks

4. Will the requested drug be used in combination with any other disease modifying multiple sclerosis (MS agent (except) agents (Note: Ampyra and Nuedexta are not disease modifying), immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)? ❑ Yes ❑ No

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Complete the following section based on the patient's diagnosis, if applicable.

Section A: Crohn's Disease

5. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #10*

6. Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #10* ❑ Yes ❑ No ❑ Unknown

7. Has the patient achieved or maintained remission? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission and no further questions.*** ❑ Yes ❑ No

8. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with Tysabri? ❑ Yes ❑ No

9. Which of the following has the patient experienced an improvement in from baseline?
   ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.
   ❑ Abdominal pain or tenderness ❑ Diarrhea ❑ Body weight
   ❑ Abdominal mass ❑ Hematocrit ❑ Endoscopic appearance of the mucosa
   ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)
   ❑ None of the above

10. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active Crohn's disease? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried.*** ❑ Yes ❑ No

Section B: Multiple Sclerosis and Clinically Isolated Syndrome

11. Is this a request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #13*

12. Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested medication? ❑ Yes ❑ No *No further questions*

13. Has the patient been tested for anti-JCV (John Cunningham virus) antibodies? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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