PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

TYSABRI® (NATALIZUMAB)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:

Q1. What is the patient's age?
- Less than 18 years
- Equal to or greater than 18 years

Q2. What is the requested duration of therapy?
- 3 months or less
- More than 3 months

Q3. For female patients, is there known or suspected pregnancy?
- Yes
- No
- Not applicable

Q4. What is the patient's diagnosis?
- Primary progressive Multiple Sclerosis
- Secondary progressive Multiple Sclerosis without relapses
- A relapsing/remitting form of Multiple Sclerosis
- Crohn's Disease
- Other

Q5. If OTHER, please specify:

Q6. Have you submitted documentation showing that you (the prescribing physician), the infusion center, and the pharmacy associated with the infusion center are registered with the TOUCH Prescribing Program?(Healthcare providers must also register with the program in order to prescribe, dispense or administer natalizumab).Details of the TOUCH Program can be found at: http://www.fda.gov/cder/drug/infopage/natalizumab/RiskMAP.pdf
- Yes
- No

Q7. Has the patient enrolled in and met all the conditions of the TOUCH Prescribing Program? (Patients must be enrolled in the TOUCH Prescribing Program (800-456-2255) to receive natalizumab).
- Yes
- No

Q8. Is this medication (Tysabri) being used as monotherapy?
- Yes
- No

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Q9. For Multiple Sclerosis, has the patient tried and failed two FDA approved disease-Modifying Drugs for multiple sclerosis (such as Copaxone and one interferon OR two interferons (Avonex, Betaseron, Rebif))?

Yes No Not Applicable

Q10. For Multiple Sclerosis, do you have a baseline MRI of the patient's brain?

Yes No Not applicable

Q11. For Crohn's Disease, has the patient tried and failed two agents from conventional CD therapies (such as corticosteroids, immunosuppressants) OR inhibitors of TNF-a (such as Humira, Remicade) or one from each category?

Yes No Not applicable

Q12. Deliver to:

Physician's Office Home Delivery

Q13. Delivery date needed:

Physician Signature **Date**

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