

**TYSABRI**  
**PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for Tysabri, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Tysabri: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information (PA#: \_\_\_\_\_)  
# pages in this request: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Long-term care facility (if applicable) contact name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

**Tysabri Dosing:**  300 mg \_\_\_\_\_  Other: \_\_\_\_\_ **Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_ (required)

**Physician Type:**  Gastroenterologist     Neurologist     Other: \_\_\_\_\_

**Specialty Pharmacy:**  Diplomat Specialty Pharmacy     Walgreens Specialty Pharmacy

**INITIAL REQUESTS**

1. Does the Recipient have a complete listing of his/her current medications?  Yes – submit list     No
2. Has the Recipient had baseline testing for the presence of anti-JC virus antibodies?  Yes – submit results     No

*Initial Requests for Multiple Sclerosis (MS)*

1. Does the Recipient have a diagnosis of a relapsing form of MS?  Yes – submit documentation     No
2. Has the Recipient had a baseline MRI of the brain performed?  Yes – submit results     No

*Initial Requests for Crohn's Disease*

1. Does the Recipient have a diagnosis of moderately to severely active disease?  Yes – submit documentation     No
2. Has the Recipient tried & failed the following treatments (check & submit documentation of dosing & duration)?

**Aminosalicylates:**  mesalamine     sulfasalazine

**Immunomodulators:**  azathioprine     methotrexate     6-mercaptopurine

**Cytokine/CAM Antagonists:**  Cimzia     Humira     Remicade

3. Does the Recipient have contraindications or intolerances to the above agents?  Yes – submit documentation     No

**RENEWAL REQUESTS**

1. Has the Recipient experienced symptom improvement or stabilization?  Yes – submit documentation     No
2. If baseline testing for anti-JC virus antibodies was negative, has the Recipient had repeat testing performed?  
 Yes – submit results     No     Question not applicable

*Requests for Crohn's Disease*

1. Was the Recipient able to discontinue use of steroid medications within 6 months of starting Tysabri?  
 Yes – submit documentation     No     Question not applicable
2. Has the Recipient required steroids to control symptoms for more than 3 months in the past year?  
 Yes – submit documentation     No     Question not applicable

**PLEASE FAX COMPLETED FORM & CLINICAL INFORMATION TO DHS – PHARMACY DIVISION**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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