

**TYSABRI (natalizumab) PRIOR AUTHORIZATION FORM**

Prior authorization guidelines for **Tysabri** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

**CLINICAL INFORMATION**

<b>Medication requested:</b> Tysabri (natalizumab) 300 mg/15 ml	<b>Quantity:</b> _____ vials	<b>Refills:</b>
<b>Directions:</b> <input type="checkbox"/> 300 mg SQ every 4 weeks <input type="checkbox"/> other: _____	<b>Dx code (required):</b>	
<b>Diagnosis:</b> <input type="checkbox"/> relapsing multiple sclerosis – <i>Submit documentation of diagnosis and disease pattern.</i> <input type="checkbox"/> moderately to severely active Crohn's disease with inflammation – <i>Submit documentation of diagnosis and disease severity.</i> <input type="checkbox"/> other: _____ – <i>Submit documentation supporting the use of Tysabri for the beneficiary's condition.</i>		
1. Is the beneficiary receiving chronic immunosuppressive or immune modulating therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit complete medication list.</i>

**INITIAL requests**

1. Does the beneficiary have results of baseline testing for anti-JC virus antibodies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
2. <b><i>For the treatment of MS</i></b> , did the beneficiary have a baseline MRI scan of the brain prior to initiating Tysabri?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
3. <b><i>For the treatment of Crohn's disease</i></b> , does the beneficiary have a history of a 3-month trial and failure of, or contraindication or intolerance to, the following medications? <i>Check all that apply.</i> <input type="checkbox"/> aminosalicylates (eg, mesalamine, sulfasalazine) <input type="checkbox"/> immune modulators (eg, azathioprine, methotrexate, 6-mercaptopurine) <input type="checkbox"/> TNF-α inhibitors (eg, Humira)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of therapeutic failure and contraindications/intolerances.</i>

**RENEWAL requests**

1. Did the beneficiary experience disease improvement or stabilization since starting Tysabri?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of beneficiary's response to therapy.</i>
2. <b><i>If baseline testing for anti-JC virus antibodies was negative</i></b> , does the beneficiary have results of repeat testing since starting Tysabri?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
3. <b><i>For the treatment of Crohn's disease</i></b> , was the beneficiary able to discontinue use of steroid medications within 6 months of starting Tysabri?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
4. <b><i>For the treatment of Crohn's disease</i></b> , did the beneficiary require steroids to control symptoms for more than 3 months in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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