pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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.

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	MA Provider ID#:
LTC facility contact/phone:		Street address:	
Beneficiary Name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	☐Tysabri (natalizumab) 300 mg/15 ml	Quantity: _____ vials	Refills:
Directions:	☐300 mg SQ every 4 weeks	☐other: _____	
Diagnosis *(submit documentation)*:			Dx code *(required)*:
Is the beneficiary currently being treated with Tysabri?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		
Is Tysabri being prescribed by or in consultation with a neurologist or gastroenterologist?	☐Yes ☐No	*Submit documentation of consultation if applicable.*	
Is the beneficiary receiving chronic immunosuppressive or immune modulating therapies?	☐Yes ☐No	*Submit complete medication list.*	

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Is being treated for multiple sclerosis
- ☐Has a relapsing form of MS

☐Is being treated for Crohn's disease
- ☐Has moderate-to-severe disease
- ☐Has disease that is associated with high-risk or poor prognostic features
- ☐Failed to achieve remission with an induction course of corticosteroids
- ☐Has a contraindication or intolerance to an induction course of corticosteroids
- ☐Failed to maintain remission with an immunomodulator (e.g., AZA, 6-MP, MTX)
- ☐Has a contraindication or intolerance to immunomodulators (e.g., AZA, 6-MP, MTX)
- ☐Tried and failed or has a contraindication or intolerance to a TNF-inhibitor (e.g., Cimzia, Humira, Remicade)
- ☐Tried and failed or has a contraindication or intolerance to ustekinumab (Stelara)
- ☐Tried and failed or has a contraindication or intolerance to vedolizumab (Entyvio)

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For a diagnosis of multiple sclerosis, experienced improvement or stabilization of the MS disease course since starting Tysabri

☐For a diagnosis of Crohn's disease:
- ☐Experienced therapeutic benefit within 3 months of starting Tysabri
- ☐Was able to discontinue concomitant steroid use within 6 months of starting Tysabri (if applicable)
- ☐Has not required concomitant steroid use for disease control for more than 3 months in the past 12 months (if >1 year since starting Tysabri)

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

Prescriber Signature:	**Date**: