# 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**

 JHHCPP SOC Tysabri SGM 1846-A – 04/2023.

**Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076**
**Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com**

**Site of Service Questions:**

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *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. What is the diagnosis?
   - ❑ 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 of multiple sclerosis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the prescribed dose and frequency? _____ mg every _____ weeks
4. Will the requested medication be used in combination with any other disease modifying multiple sclerosis (MS) 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 the requested drug being prescribed by or in consultation with a gastroenterologist? ❑ Yes ❑ No
6. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #11*
7. Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #11* ❑ Yes ❑ No ❑ Unknown
8. 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
9. 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
10. 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 and no further questions.***
    - ❑ 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
11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried.*** ❑ Yes ❑ No
12. Has the patient been tested for anti-JCV (John Cunningham virus) antibodies? ❑ Yes ❑ No

Section B: Multiple Sclerosis and Clinically Isolated Syndrome

13. Is the requested medication prescribed by or in consultation with a neurologist? ❑ Yes ❑ No
14. Is this a request for continuation of therapy? *If Yes, skip to #16* ❑ Yes ❑ No
15. Has the patient been tested for anti-JCV (John Cunningham virus) antibodies? ❑ Yes ❑ No *No Further Questions*
16. Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested medication? ❑ 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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