MedStar Health

MedStar Health
Pharmacy Services
Phone: 866-822-0750
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# TYSABRI
## Prior Authorization Form

| | |
|---|---|
| □ Standard Request<br>□ Expedited Request | If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. |

## Demographics

| Patient Information | | Prescriber Information | |
|---|---|---|---|
| Patient Name: | | Prescriber Name: | |
| DOB: | Age: | NPI#: | Specialty: |
| Health Plan ID#: | | Phone: | Fax: |
| Pharmacy Name: | Pharmacy Phone: | Office Contact: | Direct Phone # or Ext: |

## Medication Information

| Drug Requested: | Strength: | Directions: | Quantity Dispensed: | Day Supply: |
|---|---|---|---|---|
| Tysabri | 300MG/15ML Vial | | | |
| □ New medication<br>□ Continuation of therapy | Start Date: | If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy. | | |

## Billing Information

| | | |
|---|---|---|
| □ Billed by **PHARMACY** dispensed to the member *or* provider for administration. | □ Billed under **MEDICAL** benefit by provider.<br>J CODE:_____<br>ICD-10 Code:_____ | Place of Administration:<br>□ Physician's Office<br>□ Hospital/Clinic<br>□ Patient Home |

## Clinical Information

| Diagnosis: | Date Diagnosed: |
|---|---|

Is the prescribing physician registered with the TOUCH™ Prescribing program? □Yes □No
Does the member currently have or have a past history of progressive multifocal leukoencephalopathy (PML)? □Yes □No
Is the member currently on immunosuppressive or immunomodulatory therapies? □Yes □No
If yes, please list:_____
Is the member immunocompromised? □Yes □No
If yes, please describe contributing medical condition: _____

## History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

| Medication | Strength | Directions | Start Date | End Date | Reason for Discontinuing |
|---|---|---|---|---|---|
| **For Multiple Sclerosis** | | | | | |
| □Avonex | | | | | |
| □Betaseron | | | | | |
| □Copaxone | | | | | |

| Page 2 | | |
|---|---|---|
| Member Name: | DOB: | Health Plan ID: |
| *Please be sure to complete and include this page with the 1st page of this form.* | | |

| | | | | | |
|---|---|---|---|---|---|
| ☐Rebif | | | | | |
| ☐ Extavia | | | | | |
| **For Crohn's Disease** | | | | | |
| ☐Aziathioprine | | | | | |
| ☐6mercaptopurine | | | | | |
| ☐Cimiza | | | | | |
| ☐Humira | | | | | |
| ☐Remicade | | | | | |
| ☐Other (please list): | | | | | |

| **Please provide any additional information which should be considered in the space below:** |
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