Tysabri

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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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*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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Criteria Questions:

1. Has the patient been diagnosed with any of the following?
   ❑ Moderately to severely active Crohn's disease (CD)
   ❑ Relapsing form of multiple sclerosis
   ❑ Primary progressive multiple sclerosis (PPMS)
   ❑ Other ____

2. What is the ICD-10 code? ________________

Complete the following questions if patient's diagnosis is Crohn's disease.

3. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #7*

4. Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #7*

5. How long has the patient been receiving the requested medication? ______________ months
   If less than 3 months, no further questions.

6. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? *If Yes, no further questions* ❑ Yes ❑ No

7. Has the patient received any of the following medications?
   If Yes, please indicate the most recent medication and no further questions.
   ❑ Cimzia ❑ Humira ❑ Inflectra ❑ Remicade ❑ Renflexis ❑ Entyvio ❑ Stelara ❑ No

8. Has the patient tried and had an inadequate response to at least one conventional therapy option?
   If Yes, indicate below and skip to #10.
   ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
   ❑ Yes - Mesalamine, oral (Asacol, Pentasa, Delzicol, Lialda)
   ❑ Yes - Metronidazole (Flagyl)
   ❑ Yes - Ciprofloxacin (Cipro)
   ❑ Yes - Prednisone
   ❑ Yes - Budesonide (Entocort EC)
   ❑ Yes - Azathioprine (Azasan, Imuran)
   ❑ Yes - Mercaptopurine (Purinethol)
   ❑ No

9. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No

10. Has the patient had an inadequate response to a TNF inhibitor indicated for the treatment of CD (e.g., Cimzia, Humira, Remicade)? ❑ Yes ❑ No
    If Yes, indicate medication and no further questions: ____

11. Does the patient have a contraindication or intolerance to a TNF inhibitor indicated for the treatment of CD (e.g., Cimzia, Humira, Remicade)? ❑ Yes ❑ No
    If Yes, indicate medication: ____

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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