



Tysabri

Prior Authorization Request

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 **1-888-877-0518**. 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

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tysabri SGM – 11/2020.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Criteria Questions:

1. Has the patient been diagnosed with any of the following?
 - 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
 - Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used in combination with any other disease modifying multiple sclerosis (MS) agents (Note: Ampyra and Neudexta are not disease modifying), immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)? Yes No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Crohn's Disease

4. Is this request for continuation of therapy? Yes No *If No, skip to #7*
5. Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #7 Yes No Unknown
6. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with Tysabri? Yes No *If Yes, skip to #11*
7. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active Crohn's disease? *If Yes, skip to #11* Yes No

Section B: Multiple Sclerosis and Clinically Isolated Syndrome

8. Is this a request for continuation of therapy? Yes No *If No, skip to #10*
9. Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested medication? Yes No *If Yes, skip to #11*
10. Has the patient been tested for anti-JCV (John Cunningham virus) antibodies? Yes No

CD and MS Dosing

11. Does the prescribed dose exceed 300 mg? Yes No
12. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? 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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