PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tysabri

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is Tysabri being prescribed for (pick one)?

- ☐ Relapsing multiple sclerosis (MS) (complete questions 2-11)
- ☐ Moderate to severe Crohn's disease (CD) (complete questions 2-8 & 12-14)
- ☐ Other

Q2. Please provide ICD diagnosis code.

Q3. Please indicate location of administration.

- ☐ Home
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (MEMBER to obtain drug from PHARMACY with a prescription)
- ☐ Other

Q4. What specialty is the prescriber?

☐ Neurologist ☐ Gastroenterologist ☐ Other

Q5. Has the patient received an immunosuppressant in the last 3 MONTHS?

☐ Yes ☐ No

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tysabri

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

Q6. Has the patient received an antineoplastic in the last 3 MONTHS?

☐ Yes ☐ No

Q7. Does the patient have prior history of progressive multifocal leukoencephalopathy (PML)?

☐ Yes ☐ No

Q8. Does the patient have prior history of other slow-virus infection [e.g. subacute sclerosing panencephalitis (SSPE), progressive rubella panencephalitis (PRP), HIV, AIDS, rabies]?

☐ Yes ☐ No

Q9. Does the patient have prior history of a medical condition that significantly compromises the immune system (e.g. leukemia, organ transplant)?

☐ Yes ☐ No

Q10. If MS (complete questions 9-11), has the patient failed or does the patient have a contraindication to Avonex?

☐ Yes ☐ No

Q11. If MS, has the patient failed or does the patient have a contraindication to glatiramer (Copaxone)?

☐ Yes ☐ No

Q12. If MS, has the patient received interferon beta OR glatiramer (Copaxone) in the last 2 WEEKS?

☐ Yes ☐ No

Q13. If CD (complete questions 12-14), does the patient have evidence of active inflammation (e.g. elevated C-reactive protein)?

☐ Yes ☐ No

Q14. If CD, has the patient failed or does the patient have a contraindication to at least one anti-TNF agent (e.g. Humira, Cimzia, Remicade)?

☐ Yes ☐ No

Q15. If CD, has the patient received an anti-TNF agent in the last 4 WEEKS?

☐ Yes ☐ No

Q16. Additional comments

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tysabri

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.