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)
- ☐ Moderate to severe Crohn's disease (CD)
- ☐ Other

Q2. Please provide ICD diagnosis code.

Q3. What specialty is the prescriber?

☐ Neurologist ☐ Gastroenterologist ☐ Other

Q4. Is the patient a new start to therapy?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

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☐ 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, does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to Avonex?

☐ Yes ☐ No

Q11. If MS, does the patient have failure of an adequate trial of, clinically significant intolerance, or 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, does the patient have evidence of active inflammation (e.g. elevated C-reactive protein)?

☐ Yes ☐ No

Q14. If CD, does the patient have failure of an adequate trial of any of the following? Please check all that apply.

- ☐ Humira
- ☐ Cimzia
- ☐ Remicade or Renflexis
- ☐ Other (please specify)
- ☐ None of the above

Q15. If CD, does the patient have clinically significant intolerance or contraindication to the following? Please check all

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that apply.

- ☐ Humira
- ☐ Cimzia
- ☐ Remicade or Renflexis
- ☐ Other (please specify)
- ☐ None of the above

Q16. If CD, has the patient received an anti-TNF agent in the last 4 WEEKS?

☐ Yes ☐ No

Q17. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q18. Provide name and NPI of the billing entity

Q19. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q20. Additional comments

_____ _____

Prescriber Signature Date

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□ 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.