



MEDICARE FORM

Tysabri® (natalizumab) Medication Precertification Request

Page 1 of 3

All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP: FAX: 1-833-280-5224 PHONE: 1-855-463-0933

For other lines of business: Please use other form.

Note: For the treatment of Crohn's disease, Tysabri is non preferred. Renflexis is preferred for MA plans and Humira is preferred for MAPD plans. For the treatment of Multiple Sclerosis, Tysabri is preferred.

Please indicate: [] Start of treatment: Start date ___/___/___ [] Continuation of therapy: Date of last treatment ___/___/___

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

Form section A: Patient Information. Fields include First Name, Last Name, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, DOB, Allergies, E-mail, Current Weight, Height.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Office Contact Name.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Fields include Place of Administration (Self-administered, Outpatient Infusion Center, Home Infusion Center, Administration code(s)), Dispensing Provider/Pharmacy (Physician's Office, Retail Pharmacy, Specialty Pharmacy, Other), Name, Address, Phone, Fax, TIN, PIN.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for Tysabri: Dose, Frequency, HCPCS Code.

F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify any other where applicable.

Form section F: Diagnosis Information. Fields include Primary ICD Code, Secondary ICD Code, Other ICD Code.

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

Note: For the treatment of Crohn's disease, Tysabri is non preferred. Renflexis is preferred for MA plans and Humira is preferred for MAPD plans. For the treatment of Multiple Sclerosis, Tysabri is preferred.

Yes/No questions: Has the patient had prior therapy with Tysabri (natalizumab) within the last 365 days? Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)? Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any other medical reason(s) that the patient cannot use Renflexis (infliximab-abda).

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

Yes/No questions: Does the patient have a documented anti-JCV antibody test with ELISA prior to initiating treatment? Will the patient have documented anti-JCV antibody testing with ELISA annually after initiating treatment with Tysabri (natalizumab)? Is this infusion request in an outpatient hospital setting? Is the patient medically unstable for infusions at alternate levels of care? Does the patient have a history of any cardiopulmonary conditions? Does this condition cause an increased risk of severe adverse reactions?

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Patient First Name Patient Last Name Patient Phone Patient DOB

G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

Does the patient have documentation of unstable vascular access? Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load... Please document the following: GFR, BUN, Creatinine

For Initiation Requests:

Crohn's Disease

Does the patient have a diagnosis of fistulizing Crohn's disease? Please indicate how long the patient has been diagnosed with fistulizing Crohn's disease... Does the patient have a documented diagnosis of active Crohn's disease? Will Tysabri (natalizumab) be used concomitantly with immunosuppressants?

Multiple Sclerosis

Which of the following types of MS has the patient been diagnosed with: Relapsing-Remitting MS (RRMS), Primary-Progressive MS (PPMS), Progressive-Relapsing MS (PRMS), Secondary-Progressive MS (SPMS)...

For Continuation Requests (clinical documentation required for all requests):

Please indicate the length of time on Tysabri (natalizumab): Is this continuation request a result of the patient receiving samples of Tysabri (natalizumab)? Has the patient had a documented anti-JCV antibody test with ELISA within the last 12 months?

For Crohn's Disease:

Please indicate the severity of the disease at baseline (pretreatment with Tysabri (natalizumab)): mild moderate severe

For Crohn's Disease or Fistulizing Crohn's Disease:

Will Tysabri (natalizumab) be used concomitantly with immunosuppressants or TNF inhibitors (e.g., adalimumab, infliximab)?

For Multiple Sclerosis:

Which of the following types of MS has the patient been diagnosed with: Relapsing-Remitting MS (RRMS), Primary-Progressive MS (PPMS), Progressive-Relapsing MS (PRMS), Secondary-Progressive MS (SPMS)...

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Page 3 of 3

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.