



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Tysabri

Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Tysabri Other _____
2. What is the diagnosis?
 Multiple Sclerosis Crohn's Disease Other _____
3. **What is the ICD-9?** _____
4. Will Tysabri be used as monotherapy? Yes No

Complete the Section below designated for the patient's diagnosis

SECTION A: Multiple Sclerosis (MS)

5. Is the patient currently receiving treatment with Tysabri? **If Yes, Skip to # 8* Yes No
6. What form of MS does the patient have?
 Rapidly progressing form of MS Relapsing form of MS Other _____
7. Has the patient tried and had an insufficient response to other biologics for MS? Yes No

Only answer questions # 8 - 10 if patient is currently on Tysabri therapy for MS.

8. Has Tysabri been effective? Yes No
9. If No, is there a clinical reason for lack of efficacy? Yes No

10. Document clinical reason for lack of efficacy: _____
(FAX COPY)

SECTION B: Crohn's Disease

11. Is the patient between the ages of 18 and 65 years old? Yes No
12. Is the patient immunocompromised (i.e. patient has HIV, cancer, or use of immunomodulating agents or interferons that cannot be discontinued with approval of Tysabri)? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

13. Does the patient have negative tuberculosis (TB) test? **If Yes, Skip to # 16* Yes No
14. Has active TB been ruled out via negative chest x-ray? Yes No
15. Was chest x-ray taken within last 12 months? Yes No
16. Does the patient have or is susceptible to Hepatitis B or C? Yes No
17. Does the patient have or is susceptible to any other active infection? Yes No
18. **Attach baseline or current CBC with differential. (Fax copy of results)**
19. Is the CBC with differential within normal limits? Yes No
20. Will the patient's CBC with differential be monitored while on therapy? Yes No
21. **Attach documentation to support a positive therapeutic response.**
22. Does the patient have fistulizing Crohn's? **If Yes, Skip to # 31* Yes No
(Fax copy of documentation)
23. Has the patient tried and had an inadequate response to one or more of the following immunomodulatory agents? **If Yes, indicate below AND Skip to # 27* Yes No
 Azathioprine Methotrexate Mercaptopurine
24. Is the patient intolerant or contraindicated to immunomodulatory agents? Yes No
25. Has the patient tried and had an inadequate response to aminosalicylate(s) or corticosteroid(s)?
 Yes No
26. Is the patient intolerant or contraindicated to such therapy? Yes No
27. Has the patient been on the conventional therapy for at least 3 consecutive months?
 Yes No **If No, Skip to # 29*
28. Was the patient adherent to each of the prescribed therapy? Yes No
29. Does the patient have documentation of rapidly progressive disease-related symptoms while on conventional oral therapy? Yes **(Fax copy of documentation)** No
30. Was the patient unable to tolerate prescribed conventional therapy? Yes No
31. Has the patient tried and failed treatment with two of the following therapies: Cimzia, Humira or Remicade? Yes No
32. Is the patient currently receiving Tysabri? Yes No *If no, no further questions*
33. Has there been a positive therapeutic response to Tysabri treatment? Yes No
(Fax documentation to support positive response)

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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