BlueCross BlueShield Federal Employee Program

# TYSABRI
# PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

**Send completed form to:**
**Service Benefit Plan**
**Prior Approval**
**P.O. Box 52080 MC 139**
**Phoenix, AZ 85072-2080**
**Attn. Clinical Services**
**Fax: 1-877-378-4727**

| **Patient Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Date: | | | Provider Name: | | |
| Patient Name: | | | Specialty: | NPI: | |
| Date of Birth: | Sex: ❑Male ❑Female | | Office Phone: | Office Fax: | |
| Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Patient ID: R | | | Physician Signature: | | |
| **PHYSICIAN COMPLETES** | | | | | |

**NOTE**: Form must be completed in its **entirety** for processing

**Please select medication:** ❑ **Tysabri (natalizumab)** ❑ **Tyruko (natalizumab-sztn)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **3 months**, excluding samples? ***Please select answer below:***
   ❑**YES** - this is a PA renewal for the **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Crohn's Disease (CD)
   a. Does the patient have moderately to severely active Crohn's disease? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional Crohn's disease therapy? ❑Yes* ❑No
   ***If YES***, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to TNF inhibitors? ❑Yes ❑No
   c. Will this medication be used in combination with immunosuppressants or TNF inhibitors? ❑Yes* ❑No
   ***If YES***, please specify the medication(s): _____
   ❑Multiple Sclerosis (MS)
   a. Does the patient have any of the following diagnoses listed below:
   ❑Active secondary progressive multiple sclerosis (SPMS) ❑Relapsing-remitting multiple sclerosis (RRMS)
   ❑Clinically isolated syndrome (CIS) ❑Relapsing multiple sclerosis (MS)
   ❑None of the above
   b. Will this medication be used as monotherapy? ❑Yes ❑No
   c. Will this medication be used in combination with other MS disease modifying agents? ❑Yes* ❑No
   ***If YES***, please specify the medication(s): _____
   ❑Other diagnosis ***(please specify):*** _____
4. Does the patient currently have or have had progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No
5. Will the patient be monitored for any new signs or symptoms that may be suggestive of PML? ❑Yes* ❑No
   ***If YES***, will this medication be withheld at the first sign or symptom suggestive of PML? ❑Yes ❑No
6. Does the patient have significantly compromised immune system function? ❑Yes ❑No
7. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
8. **Tysabri (natalizumab) Request:** Is the patient enrolled in and meet all the conditions of the TOUCH Prescribing Program? ❑Yes ❑No
9. **Tyruko (natalizumab-sztn) Request:** Is the patient enrolled in and meet all the conditions of the Tyruko REMS Program? ❑Yes ❑No

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| **Patient Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Date: | | | Provider Name: | | |
| Patient Name: | | | Specialty: | NPI: | |
| Date of Birth: | Sex: ❑Male ❑Female | | Office Phone: | Office Fax: | |
| Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Patient ID: R | | | Physician Signature: | | |
| **PHYSICIAN COMPLETES** | | | | | |

## CONTINUATION OF THERAPY (PA RENEWAL)

**NOTE**: Form must be completed in its **entirety** for processing

**Please select medication:** ❑ **Tysabri (natalizumab)** ❑ **Tyruko (natalizumab-sztn)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **3 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** - this is a PA renewal for the **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Crohn's Disease (CD)
   a. Has the patient experienced therapeutic benefit after 12 weeks of induction therapy? ❑Yes ❑No
   b. Will this medication be used in combination with immunosuppressants or TNF inhibitors? ❑Yes* ❑No
   ***If YES***, please specify the medication(s): _____
   ❑Multiple Sclerosis (MS)
   a. Does the patient have any of the following diagnoses listed below:
   ❑Active secondary progressive multiple sclerosis (SPMS) ❑Relapsing-remitting multiple sclerosis (RRMS)
   ❑Clinically isolated syndrome (CIS) ❑Relapsing multiple sclerosis (MS)
   ❑None of the above
   b. Will this medication be used as monotherapy? ❑Yes ❑No
   c. Will this medication be used in combination with other MS disease modifying agents? ❑Yes* ❑No
   ***If YES***, please specify the medication(s): _____
   ❑Other diagnosis ***(please specify):*** _____
4. Does the patient have progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No
5. Does the patient have evidence of jaundice or liver injury? ❑Yes ❑No
6. Has the patient developed an opportunistic infection? ❑Yes ❑No
7. Has the patient developed herpes infections? ❑Yes ❑No
8. Will the patient be given live vaccines while on this therapy ? ❑Yes ❑No
9. Is the patient receiving concurrent therapy with systemic corticosteroids? ❑Yes ❑No
10. **Tysabri (natalizumab) Request:** Is the patient enrolled in and meet all the conditions of the TOUCH Prescribing Program? ❑Yes ❑No
11. **Tyruko (natalizumab-sztn) Request:** Is the patient enrolled in and meet all the conditions of the Tyruko REMS Program? ❑Yes ❑No