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** | | | | | |

## Tysabri (natalizumab)

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

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

1. Has the patient been on Tysabri 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 Tysabri be used in combination with immunosuppressants or TNF inhibitors? ❑Yes***** ❑No
   ****If YES***, please specify the medication: _____
   ❑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 Tysabri be used as monotherapy? ❑Yes ❑No
   c. Will Tysabri be used in combination with other MS disease modifying agents? ❑Yes***** ❑No
   ****If YES***, please specify the medication: _____
   ❑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 Tysabri 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 Tysabri? ❑Yes ❑No
8. Is the patient enrolled in and meet all the conditions of the TOUCH Prescribing 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)

## Tysabri (natalizumab)

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

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

1. Has the patient been on Tysabri 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 Tysabri be used in combination with immunosuppressants or TNF inhibitors? ❑Yes* ❑No
   ***If YES**, please specify the medication: _____
   ❑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 Tysabri be used as monotherapy? ❑Yes ❑No
   c. Will Tysabri be used in combination with other MS disease modifying agents? ❑Yes* ❑No
   ***If YES**, please specify the medication: _____
   ❑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 Tysabri? ❑Yes ❑No
9. Is the patient enrolled in and meet all the conditions of the TOUCH Prescribing Program? ❑Yes ❑No
10. Is the patient receiving concurrent therapy with systemic corticosteroids? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

| | |
|---|---|
| **Electronically Online** (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST** | Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.** |
| **Phone** (4-5 **minutes** for response) | The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes. |
| **Fax** (3-5 **days** for response) | Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.*** |


The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Tysabri – FEP MD Fax Form Revised 9/13/2024