Tysabri

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. 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 to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Relapsing forms of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)
   - ❑ Clinically isolated syndrome
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used in combination with any other disease modifying multiple sclerosis (MS) agents (Note: Ampyra and Neudexta are not disease modifying), immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Crohn's Disease

4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #7* ❑ Yes ❑ No ❑ Unknown
6. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with Tysabri? ❑ Yes ❑ No *If Yes, skip to #11*
7. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active Crohn's disease? *If Yes, skip to #11* ❑ Yes ❑ No

Section B: Multiple Sclerosis and Clinically Isolated Syndrome

8. Is this a request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #10*
9. Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested medication? ❑ Yes ❑ No *If Yes, skip to #11*
10. Has the patient been tested for anti-JCV (John Cunningham virus) antibodies? ❑ Yes ❑ No

CD and MS Dosing

11. Does the prescribed dose exceed 300 mg? ❑ Yes ❑ No
12. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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