Tysabri (for Maryland only)

Prior Authorization Request

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

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 **1-866-814-5506.** 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.

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

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Relapsing form of multiple sclerosis
   - ❑ Primary progressive multiple sclerosis (PPMS)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

Complete the following questions if patient has Crohn's disease.

6. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? ***If Yes, please specify the most recent medication.***
   ❑ Tysabri ❑ Cimzia ❑ Humira ❑ Inflectra ❑ Remicade ❑ Entyvio ❑ Stelara ❑ No *If No, skip to #9*
7. *If patient is continuing on therapy*, how long has the patient been receiving the requested medication? _____ weeks / months ***(circle one) If the patient has NOT received TYSABRI in a paid claim through a pharmacy or medical benefit in the previous 120 days, skip to #9.***
8. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No *No further questions*

9. Has the patient tried and had an inadequate response to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No
   If Yes, indicate the previous treatment regimen and skip to #11: _____

10. Does the patient have a contraindication or intolerance to conventional therapies listed above? ❑ Yes ❑ No
    If Yes, indicate the medication and contraindication or intolerance.
    ❑ Medication: _____
    ❑ Intolerance: _____
    ❑ Contraindication: _____

11. Has the patient had an inadequate response to a TNF inhibitor indicated for the treatment of CD (e.g., Cimzia, Humira, Inflectra, Remicade)? ❑ Yes ❑ No
    If Yes, indicate the previous treatment regimen and no further questions: _____

12. Does the patient have a contraindication or intolerance to a TNF inhibitor indicated for the treatment of CD (e.g., Cimzia, Humira, Inflectra, Remicade? ❑ Yes ❑ No
    If Yes, indicate medication: _____

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)**