



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.

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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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tysabri SGM – 01/2022.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

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? _____
Note: If patient's diagnosis is Multiple Sclerosis, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.
3. What is the prescribed dose and frequency? _____ mg every _____ weeks
4. Will the requested medication be used in combination with any other disease modifying multiple sclerosis (MS) agents (Note: Ampyra and Nuedexta are not disease modifying), immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)? Yes No

Complete the following section if the patient's diagnosis is Crohn's Disease.

5. Is this request for continuation of therapy? Yes No *If No, skip to #10*
6. Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #10 Yes No Unknown
7. Has the patient achieved or maintained remission? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission and no further questions.** Yes No
8. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with Tysabri? Yes No
9. Which of the following has the patient experienced an improvement in from baseline? **ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.**
 - Abdominal pain or tenderness
 - Diarrhea
 - Body weight
 - Abdominal mass
 - Hematocrit
 - Endoscopic appearance of the mucosa
 - Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)
 - None of the above
10. 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? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried.** Yes No
11. Has the patient been tested for anti-JCV antibodies? 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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