Neighborhood Health Plan OF RHODE ISLAND™

Tysabri Authorization form
J2323

Tel. 401-427-8200; Fax 844-639-7906

Tysabri (natalizumab) Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:

ICD 10 Codes:

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Is the patient at least 18 years of age?	☐	☐
Has the Patient had anti-JCV antibody testing with ELISA prior to initiating treatment with natalizumab and annually thereafter?	☐	☐
Will Tysabri (natalizumab) be used in combination with antineoplastic, immunosuppressant, or immunomodulating agents?	☐	☐
Does the patient have a systemic medical condition resulting in significantly compromised immune system function?	☐	☐
Multiple Sclerosis:	☐	☐
Is the patient diagnosed with a relapsing form of multiple sclerosis and documented by laboratory report (i.e. MRI)?	☐	☐
Has the patient failed, demonstrated intolerance, or has a contraindication to at least two drugs indicated for the treatment of relapsing MS?	☐	☐

Neighborhood Health Plan OF RHODE ISLAND™

Tysabri Authorization form
J2323

Tel. 401-427-8200; Fax 844-639-7906

Is the Tysabri (natalizumab) prescribed by a neurologist?	☐	☐
Will Tysabri (natalizumab) be used as monotherapy for the treatment of relapsing forms of MS?	☐	☐
Does the dose exceed 300mg (300 billable units) every 28 days?	☐	☐
Crohn's Disease:	☐	☐
Is the Patient diagnosed with Crohn's disease by a gastroenterologist?	☐	☐
Prescriber has assessed baseline disease severity utilizing an objective measure/tool?	☐	☐
Patient has had failure, intolerance, or contraindication to at least two oral immunosuppressive therapy for at least 3 months, such as corticosteroids, methotrexate, azathioprine, and/or 6-mercaptopurine?	☐	☐
Patient has had failure, intolerance, or contraindication to at least one TNF-Inhibitor therapy for at least 3 months, such as infliximab, certolizumab, or adalimumab?	☐	☐
Patient is not taking in combination with another biologic drug or immunosuppressant (e.g., 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, etc.) used for Crohn's disease?	☐	☐
Continuation of therapy:	☐	☐
Is patient tolerating treatment?	☐	☐
Does dose exceed 300mg (300 billable units) every 28 days?	☐	☐
Did patient have annual anti-JCV antibody testing with ELISA?	☐	☐
For MS patients only: Has the patient has experienced disease improvement or slowing of disease worsening (e.g., no decline in Expanded Disability Status Score [EDSS] or MRI findings) since initiating therapy?	☐	☐
For initial renewal only for Crohn's disease: Has the patient shown clinical response and remission of disease by 12 weeks?	☐	☐
For all subsequent renewals for Crohn's disease: Does the patient require additional steroid use that exceeds three months in a calendar year?	☐	☐
For all subsequent renewals for Crohn's disease: Has the patient shown disease response as indicated by improvement in signs and symptoms compared to baseline such as endoscopic activity, number of liquid stools, presence and severity of abdominal pain, presence of abdominal mass, body weight compared to IBW, hematocrit, presence of extra intestinal complications, use of antidiarrheal drugs, and/or an improvement on a disease activity scoring tool [e.g. an improvement on the Crohn's Disease Activity Index (CDAI) score or the Harvey-Bradshaw Index score?	☐	☐

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Requesting Provider:	**Date:**

Authorization is not a guarantee of payment. Member must be eligible at time of service.

Neighborhood Health Plan of Rhode Island Tel. 401-427-8200 Fax at 844-639-7906