aetna®

Tysabri® (natalizumab) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Neurologist** ☐ **Primary Care** ☐ **Gastroenterologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Tysabri: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?

☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: _____
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?

☐ Yes ☐ No Does the patient have documentation of unstable vascular access?

☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?
→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?
→ Please document the following:
☐ GFR:_____ mL/min/1.73m^2 Date Collected: ____/____/____
☐ BUN:_____ mg/dL Date Collected: ____/____/____
☐ Creatinine:_____ mg/dL Date Collected: ____/____/____

Initiation request for Crohn's Disease

☐ Yes ☐ No Does the patient have moderate to severe Crohn's disease?

☐ Yes ☐ No Is there clinical evidence that the patient has symptoms of active Crohn's disease?
→ **Please identify the symptoms:** ☐ Abdominal pain ☐ Arthritis ☐ Bleeding ☐ Diarrhea ☐ Internal fistulae ☐ Intestinal obstruction ☐ Megacolon ☐ Perianal disease ☐ Spondylitis ☐ Weight loss ☐ Other: _____

☐ Yes ☐ No Has the Crohn's disease remained active despite treatment with sulfasalazine?
→ Please indicate the date range of use: ____/____/____ - ____/____/____

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Has the Crohn's disease remained active despite treatment with immunosuppressive agents (e.g., 6-mercaptopurine or azathioprine)?
→ Please indicate the medication(s) tried and date range of use: Name: _____
Date range: ___/___/___ - ___/___/___

☐ Yes ☐ No Has the Crohn's disease remained active despite treatment with corticosteroids?
→ Please indicate which corticosteroid was tried: ☐ Hydrocortisone ☐ Methylprednisolone ☐ Prednisone ☐ Other: _____
Please indicate date range of use: Date range: ___/___/___ - ___/___/___

☐ Yes ☐ No Has the patient had an ineffective response to any of the following medications: Entyvio, Inflectra, Remicade or Stelara?
→ Please provide the names and date ranges of the medications the patient had an ineffective response to:
Medication #1: _____ Dates: ___/___/___ - ___/___/___
Medication #2: _____ Dates: ___/___/___ - ___/___/___
Medication #3: _____ Dates: ___/___/___ - ___/___/___
Medication #4: _____ Dates: ___/___/___ - ___/___/___

☐ Yes ☐ No Does the patient have a documented intolerance to any of the following medications: Entyvio, Inflectra, Remicade or Stelara?
→ Please identify which of the following medications the patient has an intolerance to: ☐ Entyvio ☐ Inflectra ☐ Remicade ☐ Stelara

☐ Yes ☐ No Does the patient have a contraindication to any of the following medications: Entyvio, Inflectra, Remicade or Stelara?
→ Please indicate which of the following medications the patient has a contraindication to: ☐ Entyvio ☐ Inflectra ☐ Remicade ☐ Stelara

☐ Yes ☐ No Will Tysabri be used concomitantly with immunosuppressants?

☐ Yes ☐ No Will Tysabri be used concomitantly with tumor necrosis factor inhibitors (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient had a documented anti-JCV antibody test with ELISA prior to initiating treatment?
→ Please indicate the date of the anti-JCV antibody test: ___/___/___

Please indicate the results of the anti-JCV antibody test with ELISA: ☐ Positive ☐ Negative

☐ Yes ☐ No Will the patient have documented anti-JCV antibody testing with ELISA annually after initiating treatment with Tysabri?

Initiation request for Multiple Sclerosis

Which of the following types of MS has the patient been diagnosed with:
☐ Relapsing-remitting MS ☐ Secondary-progressive MS ☐ Primary-progressive MS ☐ Progressive-relapsing MS

☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?

☐ Yes ☐ No Has the patient had a documented anti-JCV antibody test with ELISA prior to initiating treatment?
→ Please indicate the date of the anti-JCV antibody test: ___/___/___

Please indicate the results of the anti-JCV antibody test with ELISA: ☐ Positive ☐ Negative

☐ Yes ☐ No Will the patient have documented anti-JCV antibody testing with ELISA annually after initiating treatment with Tysabri?

How many of the following medications have been ineffective, not tolerated or contraindicated:
Aubagio, Avonex, Betaseron, Gilenya, Glatopa 20 mg or Copaxone 40 mg, Lemtrada, Plegridy, Rebif, Tecfidera? ☐ 0 ☐ 1 ☐ 2 ☐3 ☐ 4 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated or contraindicated:
☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera
→ Please identify if treatment with this medication was inffective, not tolerated or contraindicated:
☐ Ineffective ☐ Not tolerated ☐ Contraindicated
→ Please indicate which of the following describe the evidence of treatment failure:
☐ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
☐ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
☐ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
☐ Other (please explain): _____

Please indicate the ***second*** medication that has been ineffective, not tolerated or contraindicated:
☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera
→ Please identify if treatment with this medication was inffective, not tolerated or contraindicated:
☐ Ineffective ☐ Not tolerated ☐ Contraindicated
→ Please indicate which of the following describe the evidence of treatment failure:
☐ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
☐ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
☐ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
☐ Other (please explain): _____

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the ***third*** medication that has been ineffective, not tolerated or contraindicated:

☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

→ Please identify if treatment with this medication was ineffective, not tolerated or contraindicated:

☐ Ineffective ☐ Not tolerated ☐ Contraindicated

→ Please indicate which of the following describe the evidence of treatment failure:

- ☐ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
- ☐ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
- ☐ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
- ☐ Other (please explain): _____

For *Continuation* requests (Clinical documentation required for all requests):

Please indicate which diagnosis the patient is being treated for:

☐ Moderate to severe active Crohn's disease ☐ Relapsing form of multiple sclerosis

☐ Yes ☐ No Has the patient had a documented anti-JCV antibody test with ELISA within the last 12 months?

→ Please indicate the date of the anti-JCV antibody test: ____/____/____

Please indicate the results of the anti-JCV antibody test with ELISA: ☐ Positive ☐ Negative

☐ Yes ☐ No Has the patient received Tysabri within the past 6 months?

→ ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?

→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the office setting?

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Tysabri? (Sampling of Tysabri does not guarantee coverage under the provision of the pharmacy benefit)

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Will natalizumab (Tysabri) be used concomitantly with immunosuppressants or TNF inhibitors (e.g. adalimumab [Humira], infliximab [Remicade])?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.