



Tysabri® (natalizumab) Medication Precertification Request

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

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

For Medicare Advantage Part B:
 Please Use Medicare Request Form

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

Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Neurologist <input type="checkbox"/> Primary Care <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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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 Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g. acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
 Yes No Does the patient have laboratory confirmed natalizumab antibodies?
 Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
 Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety infusion therapy AND the patient does not have access to a caregiver?
 → Please provide a description of the behavioral issue or impairment: _____

Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
 → Please provide a description of the condition: Cardiovascular: _____
 Respiratory: _____
 Renal: _____
 Other: _____

Yes No Has a gap in therapy occurred?
 → Yes No Was the gap in therapy greater than 2 doses?
 Yes No Will the requested drug be used in combination with any other disease modifying multiple sclerosis (MS) agents, immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Crohn's Disease

- Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease?
- Yes No 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?
- Yes No Has the patient been tested for anti-JCV (John Cunningham virus) antibodies?

Multiple Sclerosis or Clinically Isolated Syndrome

- Yes No Has the patient been tested for anti-JCV (John Cunningham virus) antibodies?

For Continuation Requests (clinical documentation required for all requests):

Crohn's Disease

- Yes No Is the patient currently receiving Tysabri through samples or a manufacturer's patient assistance program?
- Yes No Has the patient achieved or maintained remission?
 - Yes No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with Tysabri?

Please indicate which of the following has the patient experienced:

- Abdominal pain or tenderness Abdominal mass Body weight Diarrhea Endoscopic appearance of the mucosa Hematocrit
- Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) None of the above

Multiple Sclerosis or Clinically Isolated Syndrome

- Yes No Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested medication?

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.