Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Tysabri

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have the diagnosis of multiple sclerosis?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Is the patient receiving chronic immunosuppressant or immunomodulatory therapy?

☐ Yes ☐ No

Q4. Did the patient have a magnetic resonance imaging (MRI) scan prior to initiating Tysabri therapy to help differentiate multiple sclerosis (MS) symptoms from progressive multifocal leukoencephalopathy (PML)?

☐ Yes ☐ No

Q5. Did the patient have baseline testing for anti-JC virus antibodies?

☐ Yes ☐ No

Q6. Was the baseline test for anti-JC positive?

☐ Yes ☐ No

Q7. Was the testing for anti-JC virus antibodies repeated?

☐ Yes ☐ No

Q8. Is this a request for a continuation of therapy?

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☐ Yes ☐ No

Q9. Has the patient's disease course improved or stabilized after starting Tysabri therapy?

☐ Yes ☐ No

Q10. Does the patient have the diagnosis of moderately-to-severely active Crohn's disease with inflammation?

☐ Yes ☐ No

Q11. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q12. Is the patient receiving chronic immunosuppressant or immunomodulatory therapy?

☐ Yes ☐ No

Q13. Does the patient have a documented history of therapeutic failure of a trial to one of the following aminosalicylates: a) mesalamine for 3 months or b) sulfasalazine for 3 months?

☐ Yes ☐ No

Q14. Does the patient have a contraindication or intolerance to one of the following aminosalicylates:
A) mesalamine,
B) sulfasalazine?

☐ Yes ☐ No

Q15. Does the patient have a documented history of therapeutic failure of a trial to one the following immunomodulators:
A) azathioprine for 3 months,
B) methotrexate for 3 months, or
C) 6-mercaptopurine for 3 months?

☐ Yes ☐ No

Q16. Does the patient have a contraindication or intolerance to one of the following immunomodulators:
A) azathioprine,
B) methotrexate, OR
C) 6-mercaptopurine?

☐ Yes ☐ No

Q17. Does the patient have a documented history of therapeutic failure of a trial to one of the following TNF inhibitors:
A) Cimzia for 6 weeks,
B) Humira for 3 months, OR
C) Remicade for 10 weeks?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q18. Does the patient have a contraindication or intolerance to one of the following TNF inhibitors:
A) Cimzia,
B) Humira, OR
c) Remicade?

☐ Yes ☐ No

Q19. Did the patient have baseline testing for anti-JC virus antibodies?

☐ Yes ☐ No

Q20. Is this a request for a continuation of therapy?

☐ Yes ☐ No

Q21. Is the patient taking chronic oral corticosteroids prior to starting Tysabri?

☐ Yes ☐ No

Q22. Does the patient require additional steroid use that exceeds 3 months in a calendar year to control their Crohn's disease?

☐ Yes ☐ No

Q23. Did the patient experience therapeutic benefit after 3 months of therapy?

☐ Yes ☐ No

Q24. Was the patient able to discontinue concomitant corticosteroid use within 6 months of starting therapy?

☐ Yes ☐ No

Q25. Was the baseline anti-JC virus antibody testing negative?

☐ Yes ☐ No

Q26. Did the provider repeat testing for anti-JC antibodies?

☐ Yes ☐ No

Q27. Additional Information:

☐ Yes ☐ No

Prescriber Signature _____ Date _____

Updated for 2021