



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, 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. Is this a request for a renewal of an authorization

Yes checkbox

No checkbox

Q2. Is the patient prescribed Tysabri (natalizumab) for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes checkbox

No checkbox

Q3. Is Tysabri (natalizumab) age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q4. Is the patient prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q5. Is the patient prescribed Tysabri (natalizumab) by or in consultation with an appropriate specialist (i.e., a neurologist for a diagnosis of multiple sclerosis or a gastroenterologist for a diagnosis of Crohn's disease)?

Yes checkbox

No checkbox

Q6. Does the patient have a contraindication to Tysabri (natalizumab)?

Yes checkbox

No checkbox

Q7. Does the patient have the diagnosis of moderately-to-severely active Crohn's disease with inflammation?



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

Yes No

Q8. Has the patient failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids?

Yes No

Q9. Has the patient failed to maintain remission with an immunomodulator in accordance with current consensus guidelines OR does the patient have a contraindication or intolerance to immunomodulators in accordance with current consensus guidelines?

Yes No

Q10. Does the patient have Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s) (e.g., initial diagnosis or clinical evidence supports the onset of symptoms at <30 years of age, extensive anatomic involvement, perianal and/or severe rectal disease, deep ulcers on colonoscopy, prior surgical resection, stricturing and/or penetrating behavior (AGA, 2014), need for steroid therapy at initial diagnosis, extra-intestinal manifestations (e.g., arthropathy, metabolic bone disease, cardiopulmonary disease, hepatobiliary disease, erythema nodosum, pyoderma gangrenosum, Sweet's syndrome, venous thromboembolism) (ECCO, 2017), and laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, and high fecal calprotectin levels (CAG, 2019)?

Yes No

Q11. Has the patient achieved remission with Tysabri (natalizumab)?

Yes No

Q12. Will the patient be using Tysabri (natalizumab) as maintenance therapy to maintain remission?

Yes No

Q13. Does the patient a history of therapeutic failure of at least 1 tumor necrosis factor (TNF) inhibitor indicated or medically accepted for the treatment of Crohn's disease?

Yes No

Q14. Does the patient have a history of contraindication or intolerance to the TNF inhibitors indicated or medically accepted for the treatment of Crohn's disease?

Yes No

Q15. Does the patient have a current history (within the past 90 days) of being prescribed Tysabri (natalizumab)?

Yes No

Q16. Is the patient taking chronic oral corticosteroids when starting Tysabri (natalizumab)?

Yes No

Q17. Is this a request for a renewal of an authorization for Multiple Sclerosis?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form containing fields for Patient Name, Prescriber Name, and questions Q18 through Q23 regarding documentation of improvement, Crohn's disease, corticosteroid use, and steroid use for disease control.

Prescriber Signature

Date

Updated for 2022