aetna®

MEDICARE FORM

Tysabri® (natalizumab) Medication Precertification Request

All fields must be completed and legible for precertification review.)

For Ohio MMP:
FAX: 1-855-734-9389
PHONE: 1-855-364-0974

For other lines of business:
Please use other form.

Note: For the treatment of Crohn's disease, Tysabri is non-preferred. Entyvio, Inflectra, and Remicade are preferred for MA plans and Humira and Skyrizi are preferred for MAPD plans. For the treatment of multiple sclerosis, Tysabri is preferred.

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 #: _____
Group #: _____
Insured: _____

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

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 Email:	Office Contact Name:		Phone:		

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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

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

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):

Note: For the treatment of Crohn's disease, Tysabri is non-preferred. Entyvio, Inflectra, and Remicade are preferred for MA plans and Humira and Skyrizi are preferred for MAPD plans. For the treatment of multiple sclerosis, Tysabri is preferred.

☐ Yes ☐ No Has the patient had prior therapy with Tysabri (natalizumab) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab)

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Humira (adalimumab) ☐ Skyrizi (risankizumab-rzaa)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).
☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab)

_____

_____

Continued on next page

aetna®

MEDICARE FORM

Tysabri® (natalizumab) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Ohio MMP:
FAX: 1-855-734-9389
PHONE: 1-855-364-0974

For other lines of business:
Please use other form.

Note: For the treatment of Crohn's disease, Tysabri is non-preferred. Entyvio, Inflectra, and Remicade are preferred for MA plans and Humira and Skyrizi are preferred for MAPD plans. For the treatment of multiple sclerosis, Tysabri is preferred.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).

☐ Humira (adalimumab) ☐ Skyrizi (risankizumab-rzaa)

_____

_____

☐ Yes ☐ No Does the patient have 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 (natalizumab)?

☐ 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: ____/____/____

For Initiation Requests:

Crohn's Disease

☐ Yes ☐ No Does the patient have a diagnosis of fistulizing Crohn's disease?
→ Please indicate how long the patient has been diagnosed with fistulizing Crohn's disease:
Please select: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have a diagnosis of Crohn's disease?
→ Please indicate the severity of the patient's disease: ☐ mild ☐ moderate ☐ severe
→ ☐ Yes ☐ No Does the patient have a documented diagnosis of active Crohn's disease?
→ Please select all signs/symptoms that apply:
☐ abdominal pain ☐ arthritis ☐ bleeding ☐ diarrhea ☐ internal fistulae ☐ intestinal obstruction
☐ megacolon ☐ perianal disease ☐ spondylitis ☐ weight loss ☐ None of the above
→ ☐ Yes ☐ No Have symptoms remained active despite treatment with conventional Crohn's disease therapies (e.g., sulfasalazine), corticosteroids, or immunosuppressive agents (e.g., 6-mercaptopurine, azathioprine)?
→ Please check all medications that apply: ☐ 6-mercaptopurine (6-MP) ☐ azathioprine ☐ sulfasalazine
☐ corticosteroids ☐ Other, please explain: _____
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Will Tysabri (natalizumab) be used concomitantly with immunosuppressants?

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

Multiple Sclerosis

Which of the following types of MS has the patient been diagnosed with:
☐ Relapsing-Remitting MS (RRMS) ☐ Primary-Progressive MS (PPMS) ☐ Progressive-Relapsing MS (PRMS) ☐ Secondary-Progressive MS (SPMS)

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

How many of the following preferred alternatives have treatment with an adequate trial been ineffective, not tolerated or is contraindicated?
Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya (fingolimod), Glatopa/Copaxone/glatiramer, Lemtrada (alemtuzumab), Plegridy (peginterferon beta-1a), Rebif (interferon beta-1a), Tecfidera (dimethyl fumarate)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Continued on next page

aetna®

MEDICARE FORM

Tysabri® (natalizumab) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Ohio MMP:
FAX: 1-855-734-9389
PHONE: 1-855-364-0974

For other lines of business:
Please use other form.

Note: For the treatment of Crohn's disease, Tysabri is non-preferred. Entyvio, Inflectra, and Remicade are preferred for MA plans and Humira and Skyrizi are preferred for MAPD plans. For the treatment of multiple sclerosis, Tysabri is preferred.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

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

Please indicate the length of time on Tysabri (natalizumab): _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Tysabri (natalizumab)?

☐ 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 last anti-JCV antibody test with ELISA: ____/____/____

Please indicate the results of the anti-JCV antibody test with ELISA: ☐ positive ☐ negative

☐ Yes ☐ No Has the patient received Tysabri (natalizumab) 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 there clinical documentation supporting disease stability?

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

For Crohn's Disease:

Please indicate the severity of the disease at baseline (pretreatment with Tysabri (natalizumab)): ☐ mild ☐ moderate ☐ severe

For Crohn's Disease or Fistulizing Crohn's Disease:

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

For Multiple Sclerosis:

Which of the following types of MS has the patient been diagnosed with:

☐ Relapsing-Remitting MS (RRMS) ☐ Primary-Progressive MS (PPMS) ☐ Progressive-Relapsing MS (PRMS) ☐ Secondary-Progressive MS (SPMS)

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

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.