Tysabri

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID#:**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital
❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Criteria Questions:

1. What is the diagnosis?
   - ❑ Crohn's disease
   - ❑ Relapsing form of multiple sclerosis
   - ❑ Primary progressive multiple sclerosis (PPMS)
   - ❑ Other_____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Crohn's Disease

3. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)? ❑ Yes ❑ No

4. Has the patient received Tysabri or any other biologic indicated for the treatment of Crohn's disease in a paid claim through a pharmacy or medical benefit in the previous 120 days?
   ❑ Yes ❑ No *If No, skip to #9*

5. Has the patient received any of the following medications? *If yes, please specify the most recent medication.*
   ❑ Cimzia ❑ Humira ❑ Inflectra ❑ Remicade *Skip to #7*
   ❑ Renflexis ❑ Entyvio ❑ Stelara
   ❑ No *Skip to #9*

6. Has the patient previously received treatment with Remicade for CD? ❑ Yes ❑ No *If No, skip to #8*

7. Has the patient experienced any of the following during treatment with Remicade? **ACTION REQUIRED:** ***If yes, please provide supporting documentation***
   ❑ Yes – Inadequate response *Skip to #16*
   ❑ Yes – Intolerable adverse event (e.g. hypersensitivity reaction) *Skip to #16*
   ❑ No

8. Does the patient have a contraindication to Remicade? **ACTION REQUIRED:** ***If yes, please provide supporting documentation*** ❑ Yes ❑ No *If Yes or No, skip to #16*

9. Has the patient previously received treatment with Remicade for CD? ❑ Yes ❑ No *If No, skip to #11*

10. Has the patient experienced any of the following during treatment with Remicade? **ACTION REQUIRED:** ***If yes, please provide supporting documentation***
    ❑ Yes – Inadequate response *Skip to #12*
    ❑ Yes – Intolerable adverse event (e.g. hypersensitivity reaction) *Skip to #12*
    ❑ No

11. Does the patient have a contraindication to Remicade? **ACTION REQUIRED:** ***If yes, please provide supporting documentation*** ❑ Yes ❑ No

12. Has the patient tried and had an inadequate response to at least **ONE** conventional therapy options (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda, Rowasa], Balsalazide [Colazal], olsalazine [Dipentum], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, prednisolone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No *If No, skip to #14*

13. Please indicate the previous treatment regimen and *skip to #16.*

_____

14. Does the patient have a contraindication or intolerance to at least **ONE** conventional therapy options (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda, Rowasa], Balsalazide [Colazal], olsalazine [Dipentum],, mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, prednisolone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])? ❑ Yes ❑ No

15. Please indicate the contraindication or intolerance.

    _____

16. Is this a request for a continuation of therapy with Tysabri? ❑ Yes ❑ No *If No, no further questions*

17. How long has the patient been receiving the requested medication? _____months

18. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No *No further questions*

Section B: Multiple Sclerosis

19. Has the patient been diagnosed with relapsing form of multiple sclerosis (MS)? ❑ Yes ❑ No

20. Has the patient tried and had an inadequate response, intolerance or contraindication to at least one alternative medication indicated for the treatment of multiple sclerosis (e.g., interferon beta-1b [Betaseron], glatiramer acetate injection [Copaxone], interferon beta-1a [Rebif], peginterferon beta-1a [Plegridy], teriflunomide [Aubagio], fingolimod [Gilenya], dimethyl fumarate [Tecfidera])? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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