05/02/14

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Tysabri (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Tysabri (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Tysabri (natalizumab)
Quantity _____ Frequency _____ Strength _____
Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If no, skip to question 7.]

2. Has the patient received Tysabri therapy for less than 6 months? Y N

   [If no, skip to question 4.]

3. Is there documentation supporting a response to therapy? Y N

   [No further questions]

4. Has the patient received between 6 months and 2 years of Tysabri therapy? Document start date of treatment: Y N

   [If no, no further questions.]

5. Has the patient received Tysabri therapy for 2 years or more? Y N

   [If yes, no further questions]

6. Is there documentation supporting patient meets one of the following: Y N

   Multiple sclerosis: patient is responding to therapy \
   Crohn's disease: patient has been able to taper off of corticosteroid therapy

   [No further questions.]

7. Is the patient 18 years of age or older? Y N

   [If no, no further questions.]

8. Does the patient meet both of the following criteria? Y N

   Tysabri will be used as monotherapy, AND \ Patient will not be taking antineoplastic, immunosuppressive, or immunomodulating agents (e.g., azathioprine, 6-mercaptopurine, cyclosporine, methotrexate, TNF-inhibitors).

   [If no, no further questions.]

9. Does the patient have a diagnosis of relapsing-remitting multiple sclerosis (RRMS)? Y N

   [If no, skip to question 12.]

10. Is Tysabri prescribed by a neurologist? Y N

    [If no, no further questions.]

11. Has the patient failed a compliant regimen of at least two formulary medications (e.g., Avonex, Rebif, Betaseron, Extavia, Copaxone)? Please document medications tried: Y N

    [No further questions.]

12. Does the patient have a diagnosis of Crohn's disease (CD)? Y N

    [If no, no further questions.]

13. Is Tysabri prescribed by a gastroenterologist? Y N

    [If no, no further questions.]

14. Does the patient meet ONE of the following criteria? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to corticosteroids, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of oral corticosteroids (for moderate to severe CD) or intravenous corticosteroids (for severe and fulminant CD) for one month OR \ Documented contraindication or intolerance to PO or IV corticosteroids

    [If no, no further questions.]

15. Does the patient meet ONE of the following criteria? Please indicate which of the below apply to patient (if patient has contraindication/intolerance to azathioprine or mercaptopurine, list contraindication/intolerance): Y N

    Trial and failure of a compliant regimen of azathioprine or mercaptopurine for three consecutive months OR \ Documented contraindication or intolerance to azathioprine or mercaptopurine

    [No further questions.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**