Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

TYSABRI
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Tysabri	300MG/15ML Vial			
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

Is the prescribing physician registered with the TOUCH™ Prescribing program? □Yes □No

Does the member currently have or have a past history of progressive multifocal leukoencephalopathy (PML)? □Yes □No

Is the member currently on immunosuppressive or immunomodulatory therapies? □Yes □No

If yes, please list:_____

Is the member immunocompromised? □Yes □No

If yes, please describe contributing medical condition: _____

History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Medication	Strength	Directions	Start Date	End Date	Reason for Discontinuing
For Multiple Sclerosis					
☐ Avonex					
☐ Betaseron					
☐ Copaxone					
☐ Rebif					
☐ Extavia					
For Crohn's Disease					
☐ Aziathioprine					
☐ 6mercaptopurine					
☐ Cimiza					
☐ Humira					
☐ Remicade					
☐ Other (please list):					

Please provide any additional information which should be considered in the space below: