CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Tysabri® (natalizumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 340 Multiple Sclerosis ☐ _____ Crohn's Disease ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient is 18 years of age or older ☐ Yes ☐ No
- Tysabri will be used as monotherapy ☐ Yes ☐ No
- Patient is currently on other immune system modifying drugs such as antineoplastics, immunosuppressants, or immunomodulators ☐ Yes ☐ No
- Patient has a medical condition which significantly compromised the immune system including HIV infection or AIDS, leukemia, or lymphoma or organ transplantation ☐ Yes ☐ No
- Patient has a current or prior history of progressive multifocal leukoencephalopathy (PML) ☐ Yes ☐ No
- Patient has enrolled in and met all conditions of the TOUCH (Tysabri Outreach: Unified Commitment to Health) Prescribing Program ☐ Yes ☐ No

If diagnosis of relapsing forms of Multiple Sclerosis (MS)

- Patient has had a gadolinium – enhanced MRI scan of the brain and, when indicated, cerebrospinal fluid analysis to help differentiate potential future MS symptoms from PML as required by the FDA ☐ Yes ☐ No
- Has the patient tried and failed at least one other treatment for MS (interferon beta or Copaxone) or are all treatments contraindicated? ☐ Yes ☐ No

If diagnosis of moderate to severe active Crohn's disease

- Is patient currently receiving Tysabri? ☐ Yes ☐ No
- Patient has had an inadequate response or is unable to tolerate conventional therapies (sulfasalazine, mesalamine products, corticosteroids, immunosuppressants [6-mercaptopurine, azathioprine, cyclosporine, or methotrexate]) ☐ Yes ☐ No
- Patient has had an inadequate response or is unable to tolerate Remicade **AND** Humira ☐ Yes ☐ No
- Tysabri will be used concomitantly with immunosuppressants (6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) ☐ Yes ☐ No
- Is patient on chronic oral corticosteroids ☐ Yes ☐ No
  - **If yes**, will tapering begin as soon as therapeutic benefit of Tysabri has occured ☐ Yes ☐ No
  - Patient has been on Tysabri for 6 months ☐ Yes ☐ No
    - **If yes**, tapering has begun ☐ Yes ☐ No
- Patient has experienced therapeutic benefit by 12 weeks of induction therapy ☐ Yes ☐ No
- What date did the patient begin therapy with Tysabri? _____

• **Authorization #:** _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Tysabri® (natalizumab)	☐ 300mg/15ml			

PRODUCT SUBSTITUTION PERMITTED (Date)

DISPENSE AS WRITTEN (Date)