

PREAUTHORIZATION FORM
Tysabri®
 (natalizumab)

Therapeutic use: Treatment of patients with relapsing forms of MS to delay the accumulation of physical disability and reduce the frequency of clinical exacerbations

Quantity Limit: 300 mg IV infusion every four weeks

Authorization Period: 6 months

Patient's name _____

Patient's ID# [][][][][][][][][] DOB [][] / [][] / [][][][][]

ICD-9 [][][][][][][][][] _____

Physician's name _____

Physician's Ph# ([][][][]) [][][][] - [][][][][] Fax# [][][][] - [][][][][]

Physician's signature _____ Date signed [][] / [][] / [][][][][]

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:

1.	For Multiple Sclerosis , is the prescribing physician a neurologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No												
1a.	Has the patient been COMPLIANT on another MS drug? If so, please list the therapies that have been tried in the table below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No												
	<table border="1"> <thead> <tr> <th>Name of Drug</th> <th>Duration of Therapy</th> <th>Reason for Discontinuation</th> </tr> </thead> <tbody> <tr> <td>a.</td> <td></td> <td></td> </tr> <tr> <td>b.</td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> </tbody> </table>	Name of Drug	Duration of Therapy	Reason for Discontinuation	a.			b.			c.				
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b.															
c.															
1b.	For MS , anti-natalizumab antibody assays are required after 12 weeks and 24 weeks of therapy. Week 12: Antibody concentration: _____ Date of assay: _____ Week 24: Antibody concentration: _____ Date of assay: _____														
2.	For Crohn's Disease , is the prescribing physician a gastroenterologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No												
2a.	Has the patient been COMPLIANT on a TNF-alpha drug for the treatment of CD ? If so, please list the therapies that have been tried in the table below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No												
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b.															
<ul style="list-style-type: none"> Tysabri should not be used if the patient currently immunosuppressed. 															

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.