Tysabri® (natalizumab)
Tyruko® (natalizumab-sztn)
Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:	Office Contact Name:	Phone:			

Specialty *(Check one)*: ☐ **Neurologist** ☐ **Primary Care** ☐ **Gastroenterologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Tysabri (natalizumab)** ☐ **Tyruko (natalizumab-sztn)**
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
☐ Yes ☐ No Does the patient have laboratory confirmed natalizumab antibodies?
☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____
☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: ☐ Cardiovascular: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

☐ Yes ☐ No Has a gap in therapy occurred?
→ ☐ Yes ☐ No Was the gap in therapy greater than 2 doses?

☐ Yes ☐ No Will the requested drug be used in combination with any other disease modifying multiple sclerosis (MS) agents (Note: Ampyra and Nuedexta are not disease modifying), immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ **Crohn's disease**
- ☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a gastroenterologist?
- ☐ Yes ☐ No Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for moderately to severely active Crohn's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
- ☐ Yes ☐ No Has the patient been tested for anti-JCV (John Cunningham virus) antibodies?

☐ **Clinically isolated syndrome of multiple sclerosis**
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a neurologist?
- ☐ Yes ☐ No Has the patient been tested for anti-JCV (John Cunningham virus) antibodies?

☐ **Relapsing forms of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)**
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a neurologist?
- ☐ Yes ☐ No Has the patient been tested for anti-JCV (John Cunningham virus) antibodies?

For Continuation Requests (clinical documentation required for all requests):

☐ **Crohn's disease**
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a gastroenterologist?
- ☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
- ☐ Yes ☐ No Has the patient achieved or maintained remission?
  - → ☐ Yes ☐ No Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
    Please indicate which of the following the patient experienced an improvement from baseline:
    ☐ Abdominal pain or tenderness ☐ Abdominal mass ☐ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ☐ Body weight ☐ Diarrhea ☐ Hematocrit ☐ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ☐ None of the above

☐ **Clinically isolated syndrome of multiple sclerosis**
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a neurologist?
- ☐ Yes ☐ No Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested drug?

☐ **Relapsing forms of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)**
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a neurologist?
- ☐ Yes ☐ No Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested drug?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.