Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Tysabri for Crohn's (Medicaid)

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 at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Tysabri for Crohn's (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Tysabri (natalizumab)

Other, please specify_____

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

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

   [If no, skip to question 3.]

2. Is the patient in remission without requiring more than 5mg of prednisone daily? Y N

   [No further questions.]

3. Does the patient have a diagnosis of Crohn's Disease? Y N

   (NOTE: Requests for the treatment of multiple sclerosis (MS) should be requested using the MS Agents prior authorization

form.)

[If no, then no further questions.]

4. Has the patient had inadequate response or intolerable side effects to IV corticosteroids after 7-10 days or oral prednisone (dosed at 40mg or more per day for 30 days)? Y N

   [If yes, skip to question 8.]

5. Does the patient have steroid-dependent Crohn's disease as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

   [If no, then no further questions.]

6. Has the patient had failure to an adequate trial (3 months) of azathioprine (AZA), mercaptopurine (6-mp) or injectable methotrexate? Y N

   [If yes, skip to question 8.]

7. Does the patient have a contraindication to all of the following: azathioprine (AZA), injectable methotrexate and mercaptopurine (6-mp)? Y N

   If yes, please document contraindication(s):
   _____

   [If no, then no further questions]

8. Has the patient had a trial and failure of at least one formulary anti-TNF (tumor necrosis factor inhibitor)? Y N

   Note: Refer to formulary for covered anti-TNF agents.

   [If no, then no further questions.]

9. Is the patient at least 18 years of age? Y N

   [If no, then no further questions.]

10. Is Tysabri being prescribed by, or in consultation with a gastroenterologist? Y N

    [If no, then no further questions.]

11. Will Tysabri be given in combination with any antineoplastic, immunosuppressive, or immunomodulating agents (e.g., azathioprine, 6-mercaptopurine, cyclosporine, methotrexate, anti-TNFs? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date