Tyruko, Tysabri
(natalizumab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Tyruko 300 mg/15 mL vial
☐ Tysabri 300 mg/15 mL vial

Directions for use: Dose and Quantity: Duration of therapy:

J-Code:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy with the requested medication?

☐ New start (initial therapy OR restart)
☐ Continuation of therapy

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

Will the requested medication be given in combination with a BIOLOGIC or in combination with a targeted synthetic oral small molecule drug or with another potent immunosuppressant?
☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), an ustekinumab product [Stelara (IV or SC), biosimilars], Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)
☐ Potent immunosuppressant (for example, 6-mercaptopurine, azathioprine, cyclosporine, and methotrexate)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC, targeted synthetic oral small molecule drug, or potent immunosuppressant

What is the indication or diagnosis?
☐ Relapsing form of multiple sclerosis (MS) Please Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease.
☐ Crohn's disease
☐ Non-relapsing forms of multiple sclerosis (MS) Please Note: An example of a non-relapsing form of multiple sclerosis is primary progressive multiple sclerosis.
☐ Ulcerative colitis
☐ All other indications

(if MS) Is the patient using the requested medication in combination with other disease-modifying agents used for MS? Please Note: Examples of disease-modifying agents for multiple sclerosis include Betaseron, Rebif, Copaxone, Glatopa, glatiramer acetate injection, Avonex, Lemtrada, Plegridy, Ponvory, Gilenya, Aubagio, Tecfidera, dimethyl fumarate delayed-release capsules, Vumerity, Mayzent, Mavenclad, Kesimpta, Bafiertam, Zeposia, teriflunomide tablets, Briumvi, Tascenso ODT, Tyruko, fingolimod capsules, Ocrevus, and Ocrevus Zunovo. ☐ Yes ☐ No

(if MS) Is this medication being prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis? ☐ Yes ☐ No

(if MS) Is the patient currently receiving natalizumab? ☐ Yes ☐ No

(if MS, not currently receiving) According to the prescriber has the patient experienced inadequate efficacy or significant intolerance to ONE disease-modifying agent used for MS? - Please Note: Examples of disease-modifying agents for multiple sclerosis include Betaseron, Rebif, Copaxone, Glatopa, glatiramer acetate injection, Avonex, Lemtrada, Plegridy, Ponvory, Gilenya, Aubagio, Tecfidera, dimethyl fumarate delayed-release capsules, Vumerity, Mayzent, Mavenclad, Kesimpta, Bafiertam, Zeposia, teriflunomide tablets, Briumvi, Tascenso ODT, Tyruko, fingolimod capsules, Ocrevus, and Ocrevus Zunovo. ☐ Yes ☐ No

(if no) According to the prescriber does the patient have highly active or aggressive multiple sclerosis? ☐ Yes ☐ No

Has the patient demonstrated rapidly advancing deterioration(s) in physical functioning? PLEASE NOTE: Examples include loss of mobility or lower levels of ambulation and severe changes in strength or coordination. ☐ Yes ☐ No

(if no) Does the patient have disabling relapse(s) with suboptimal response to systemic corticosteroids? ☐ Yes ☐ No

(if no) Does the patient have magnetic resonance imaging [MRI] findings that suggest highly active or aggressive multiple sclerosis? PLEASE NOTE: Examples include new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions. ☐ Yes ☐ No

(if no) Does the patient have manifestations of multiple sclerosis-related cognitive impairment? ☐ Yes ☐ No

(if MS, currently receiving) Has the patient been receiving natalizumab for 1 year or more? ☐ Yes ☐ No

(if currently receiving for 1yr+) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? - Please Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12-Item Multiple Sclerosis Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss. ☐ Yes ☐ No

(if no) Has the patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation? ☐ Yes ☐ No

(if Crohn's) Is the requested medication being prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

(if Crohn's) Is the patient currently receiving natalizumab? ☐ Yes ☐ No

(if currently receiving natalizumab, Crohn's) Has the patient been established on therapy for at least 6 months? Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy. ☐ Yes ☐ No

(if not currently receiving or receiving for less than 6 months) Does the patient have moderately to severely active Crohn's disease? ☐ Yes ☐ No

(if Crohn's, not currently receiving or receiving for less than 6 months) Has the patient tried at least two advanced therapies indicated for use in Crohn's disease? Please Note: Advanced therapies include biologics and a Janus kinase inhibitor indicated for Crohn's disease. Each biosimilar tried from the same chemical would only count as a trial of one product. Examples include an adalimumab product (Humira, biosimilars), Cimzia, an infliximab IV product (Remicade, biosimilars), Zymfentra, Entyvio (IV or SC), Omvoh (IV or SC), Rinvoq, Skyrizi (IV or SC), Tremfya (IV or SC), or an ustekinumab product (Stelara [IV or SC], biosimilars). ☐ Yes ☐ No

(if established for 6+months and Crohn's) Has the patient experienced a beneficial clinical response from baseline (prior to initiating natalizumab), when assessed by at least one objective measure? Please Note: Examples of objective measures include fecal markers (for example renal lactoferrin, fecal calprotectin), serum markers (for example, C-reactive protein), imaging studies (magnetic resonance enterography [MRE], computed tomography enterography [CTE]), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Has the patient experienced an improvement, compared with baseline (prior to initiating natalizumab), in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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