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:
☐ Tysabri 300 mg/15 mL vial

Directions for use: Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

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*

*I*s this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick new start.
☐ new start
☐ continuation of therapy

(if continuation of therapy) Has your patient had a documented beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of this drug. _____

***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

Diagnosis related to use:

☐ Active Secondary Progressive Multiple Sclerosis (SPMS) (for example, SPMS with a documented relapse)
☐ Clinically Isolated Syndrome (CIS)
☐ moderate to severe Crohn's disease
☐ Non-Relapsing Forms of Multiple Sclerosis (for example, primary progressive multiple sclerosis [PPMS])
☐ Relapsing-Remitting Multiple Sclerosis (RRMS)
☐ Ulcerative Colitis
☐ other (Please specify):

Clinical Information:

(if Crohn's) Is this medication being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in Crohn's disease? ☐ Yes ☐ No

(if Crohn's) Besides this medication, other immunosuppressant agents for Crohn's Disease include: 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, an infliximab IV product, Zymfentra (infliximab-dyyb subcutaneous injection), an adalimumab product, Cimzia, Entyvio IV, Skyrizi (risankizumab-rzaa intravenous infusion and subcutaneous injection on-body injector), Stelara, and Rinvoq (upadacitinib extended-release tablets). Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another drug.
☐ Unknown

(if other/more than the requested drug) Please provide the rationale for concurrent use.

(if Crohn's) The covered alternatives are anti-tumor necrosis factor biologics (such as, adalimumab products [adalimumab-ADAZ, adalimumab-FKJP, Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, Yusimry], Cimzia, Enbrel, Simponi/Simponi Aria, infliximab products [Avsola, Inflectra, Remicade, Renflexis]). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Crohn's) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the covered alternatives, but they did not tolerate it.
☐ The patient can't try the alternative because of a contraindication to this drug.
☐ Other

(if MS) Besides the drug being requested, other disease-modifying agents used for multiple sclerosis include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, dimethyl fumarate, fingolimod, glatiramer, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera, teriflunomide, Vumerity, and Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another drug.
☐ Unknown

(if other/more than the requested drug) Please provide the rationale for concurrent use.

(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 new, if MS) Does the patient have highly-active or aggressive multiple sclerosis? ☐ Yes ☐ No

(if yes) Does the patient demonstrate rapidly-advancing deterioration(s) in physical functioning (for example, loss of mobility/or lower levels of ambulation, severe changes in strength or coordination)? ☐ Yes ☐ No

(if no) Is there documentation that the patient has disabling relapse(s) with suboptimal response to systemic corticosteroids? ☐ Yes ☐ No

(if no) Has the patient had magnetic resonance imaging (MRI) with findings suggesting highly-active or aggressive multiple sclerosis (for example, new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions)? ☐ Yes ☐ No

(if no) Is there documentation that the patient has cognitive impairment related to multiple sclerosis (for example, deficits in short-term or long-term memory, visual spatial ability deficits)? ☐ Yes ☐ No

(if new, MS) The covered alternatives are dimethyl fumarate delayed-release capsules (generic for Tecfidera) [may require prior authorization] and fingolimod (generic for Gilenya) [may require prior authorization]. If your patient has tried these drugs, please provide name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried these drugs, please provide details why your patient can't try these alternatives..

(if MS) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient can't try BOTH alternatives because of a contraindication to each drug.
☐ Other

Additional pertinent information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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