Tysabri

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
  TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

SECTION A Please answer the following questions

1. θ Yes θ No Is Tysabri supplied by retail, home infusion, long term care (LTC) or other pharmacies?
2. θ Yes θ No Is Tysabri supplied and administered by a physician's office?
   (please document how medication is being supplied and administered below):

   _____
3. θ Yes θ No Will Tysabri be used in a patient with progressive multifocal leukoencephalopathy (PML) or a history of PML?
4. Is the indication or diagnosis for the treatment of a patient with relapsing forms of multiple sclerosis to delay the accumulation of physical disability and reduce the frequency of clinical exacerbations?
   θ Yes → ***please answer questions 5 & 6***
   θ No → ***please answer questions 7 - 14***
5. θ Yes θ No Has the member used (or has the member had inadequate response to, or is the member unable to tolerate) at least one of the following MS therapies: for example, fingolimod (Gilenya), dimethyl fumarate (Tecfidera), interferon beta

1a (Avonex), interferon beta-1b (Betaseron), glatiramer acetate, interferon beta-1a (Rebif), peginterferon beta-1a (Plegridy), etc.?
(Please document (1) medications used (2) inadequate response, contraindications or adverse outcome (3) anticipated significant adverse clinical outcome below):

6. θ Yes θ No Is Tysabri being written or recommended by a neurologist?
7. θ Yes θ No Is the indication or diagnosis for the treatment of Crohn's Disease (CD)?
8. θ Yes θ No Will Tysabri be used in combination with immunosuppressants (for example, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, etc.) or TNF-alpha inhibitors (e.g., Humira, Cimzia, Remicade, etc.)?
9. θ Yes θ No Is Tysabri being written or recommended by a gastroenterologist?
10. Has the member used Tysabri before?
    θ Yes → ***please answer questions 11 & 12***
    θ No → ***please answer questions 13 & 14***
11. θ Yes θ No Has the member demonstrated remission or significant clinical response to Tysabri with its previous use?
12. θ Yes θ No Has the member been on concomitant corticosteroid treatment after 6 months on Tysabri, or received more than 3 months of the corticosteroid in a calendar year while on Tysabri?
13. θ Yes θ No Does the member have diagnosis of moderate-to-severe Crohn's Disease with evidence of inflammation?
14. θ Yes θ No Has the member used (or has the member had inadequate response to, or are unable to tolerate) at least one conventional Crohn's Disease therapy (e.g., aminosalicylates: Asacol, mesalamine, Delzicol, etc., or corticosteroids: prednisone, etc., or immunomodulators: 6-mercaptopurine, etc.) and at least one TNF blocker (e.g. Humira, Remicade, etc.)?
(Please document (1) medications used (2) inadequate response, contraindications or adverse outcome (3) anticipated significant adverse clinical outcome below):

Please document the symptoms and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.scanhealthplan.com