SENDERO HEALTH PLANS

Prior Authorization Request Form	**Tysabri**
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
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)**

Provider Information	**Patient Information**
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**
Indicate where the drug is being DISPENSED	**Indicate where the drug is being ADMINISTERED**
☐ **Ambulatory Surgery Center** ☐ **Home Care Agency** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):**	☐ **Ambulatory Surgery Center** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):** **Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with any of the following?
   - ☐ Crohn's disease (CD)
   - ☐ Multiple sclerosis (MS) – relapsing forms
   - ☐ Other: _____

2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____

3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No

4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No

5. What were the results of the TB screening test? ☐ Positive ☐ Negative

6. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
   ☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

8. Doe the patient have a history of progressive multifocal leukoencephalopathy (PML) due to JC virus infection?
   ☐ Yes ☐ No

9. Is there clinical suspicion that the patient may have PML? ☐ Yes ☐ No

10. Has the patient been tested for anti-JC virus antibodies within 6 months of initiating or continuing therapy? ☐ Yes – positive test ☐ Yes – negative test ☐ No – not yet tested

11. Is this request for continuation of therapy? ☐ Yes ☐ No

12. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

13. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS SECTION: ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A. Crohn's Disease

14. There is documentation of moderate to severe Crohn's disease per the Crohn's Disease Activity index (CDAI):
    - ☐ Mild = CDAI <220
    - ☐ Moderate = CDAI 220-450
    - ☐ Severe = CDAI >450

15. There is documentation of 1 or more of the following high-risk features:
    - ☐ Diagnosis at age <30 years
    - ☐ Ileal disease
    - ☐ Penetrating or stricturing disease
    - ☐ Perianal or severe rectal disease
    - ☐ Extra-intestinal manifestations
    - ☐ History of bowel resections
    - ☐ Initial extensive bowel involvement on endoscopy
    - ☐ None

16. The treatment is prescribed by or in consultation with a gastroenterologist ☐ Yes ☐ No

17. Has the patient previously received a biologic indicated for Crohn's disease? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

18. Does the patient have perianal or fistulizing Crohn's disease? ☐ Yes ☐ No

19. Does the patient have a concomitant diagnosis of multiple sclerosis? ☐ Yes ☐ No

20. Has the patient had an inadequate response to a minimum 3 month trial at the maximally indicated dose of 1 or more of the following within the last 6 months?
    If Yes, indicate below and no further questions.
    - ☐ Sulfasalazine
    - ☐ Mesalamine (if primarily colonic disease)
    - ☐ Azathioprine at minimum dose 1.5 mg/kg daily
    - ☐ 6-mercaptopurine at minimum dose 50mg daily
    - ☐ Methotrexate at minimum dose 15mg IM or SQ weekly
    - ☐ Systemic corticosteroids (prednisone, methylprednisolone)
    - ☐ None of the above therapies have been trialed

21. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
    If yes, please document medications and respective contraindications/intolerances:
    _____

* Please note, the preferred biologic class is a TNF inhibitor (specifically Cimzia), followed by Stelara, followed by Entyvio after failure of a TNF inhibitor. Please consider prescribing 1 of these drugs before Tysabri if clinically appropriate. If Tysabri is preferred over these agents, please provide additional clinical reasoning documentation here:

_____

Section E: Multiple Sclerosis

22. Has the patient previously received a biologic indicated for multiple sclerosis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:

    _____

23. Does the patient have a relapsing form of multiple sclerosis (clinically isolated syndrome, relapsing-remitting MS, or active secondary progressive disease)? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.

Prescriber or Authorized Signature	DATE