☐ Preferred drug accepted. New verbal order authorized.
☐ **Preferred** drug rejected by physician.

# Health New England

## *Medication Request Form (MRF /Prescription Request*

## *Tysabri ® (natalizumab)*

| DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY |
|---|
| Contacted: |
| Physician: |
| Pharmacy: |
| Patient: |
| |
| |

**Prior Authorization**

☐ **Prior Authorization Only**

☐ **Prior Authorization and Drug Delivery Request**

| DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY |
|---|
| Approved: |
| Quantity approved: |
| PA from and thru date: |
| PA # |
| Denied: |
| Returned: |

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Tysabri ®. Please complete this form and fax to ICORE Healthcare at **(866)-364-2673**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 775-5138**.

**J-Code: Q4079, unit = 1mg**

**Medication Request Information (please complete each section of this form prior to transmittal):**

| Patient Information (all required) | Physician Information (all required) |
|---|---|
| **Patient Name:** | **Physician Name:**<br>**Specialty:** |
| **Patient Cell Phone #: (  )  -** | **NPI #:** |
| **Patient HNE ID#:** | **HNE Provider #:** |
| **Patient Date of Birth:** | **DEA #:** |
| **Allergies:** | **Telephone #: (  )  -** |
| **Diagnosis:** | **Fax # (required): (  )  -** |

| Drug Information | | |
|---|---|---|
| **Preferred Drug/Strength/Form:** ☐ **Copaxone** ☐ **Rebif** | | |
| **Requested Drug/Strength/Form:** | | |
| **Dose, Directions, and length of treatment (please be specific):** | **Quantity (per month):** | **Refills:** |
| **Physician Signature:** **Date:** | | |

**Indication:**

☐ Monotherapy for relapsing forms of multiple sclerosis
☐ Crohn's Disease
☐ Other (please describe): ______________________________

**Documentation of Medical Necessity** (*check all that apply*):

☐ The prescribing physician is a neurologist AND a member of the TOUCH program
☐ The infusion facility is part of the TOUCH program
☐ The patient does NOT have a diagnosis of progressive multifocal leukoencephalopathy (PML)
☐ The patient has tried and failed at least one of the following: Avonex, Betaseron, Rebif, Copaxone or Novantrone
☐ The latest MRI shows continued CNS lesion progression (date of latest MRI is __________________)
☐ Other pertinent history: ______________________________