Cigna®

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:

Is 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

Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

Please provide support for continued use.

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

What is the patient's diagnosis or reason for treatment?

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

Clinical Information:

If SPMS, CIS, or RRMS :

Has the patient experienced inadequate efficacy or significant intolerance to one disease-modifying agent used for multiple sclerosis, according to the prescriber? Notes: Examples include Aubagio (teriflunomide), Avonex, Bafiertam, Betaseron, Briumvi, Copaxone (glatiramer), Extavia, Gilenya (fingolimod), Glatopa, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera (dimethyl fumarate), Tyruko, Vumerity, and Zeposia. ☐ Yes ☐ No

Does the patient have highly active or aggressive multiple sclerosis according to the prescriber? ☐ Yes ☐ No

Has the patient demonstrated rapidly advancing deterioration(s) in physical functioning (for example, loss of mobility or lower levels of ambulation and severe changes in strength or coordination)? ☐ Yes ☐ No

Is the patient experiencing disabling relapse(s) with suboptimal response to systemic corticosteroids? ☐ Yes ☐ No

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

Is the patient having manifestations of multiple sclerosis-related cognitive impairment? ☐ Yes ☐ No

Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Notes: 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 Status 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

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

Is this medication prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of multiple sclerosis? ☐ Yes ☐ No

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 medication at this time, nor will they in the future. The requested medication is the only medication the patient is/will be using.
☐ The patient is currently on another medication, but this medication will be stopped and the requested medication will be started
☐ The patient is currently on another medication, and the requested medication will be added. The patient may continue to take both medications together.
☐ Other

Please provide the rationale for concurrent use.

Is this medication prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of multiple sclerosis? ☐ Yes ☐ No

<u>If Crohn's disease:</u>

Is the patient using Tysabri in combination with an immunosuppressant agent? Please Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, an infliximab IV product, an adalimumab product, Cimzia, Entyvio IV, Skyrizi, Zymfentra, Rinvoq, and Stelara. ☐ Yes ☐ No

Is Tysabri prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

Is the patient currently receiving Tysabri? ☐ Yes ☐ No

Has the patient been established on therapy for at least 6 months? ☐ Yes ☐ No
Does the patient have moderately to severely active Crohn's disease? ☐ Yes ☐ No

Has the patient tried at least two biologics for Crohn's disease? Please Note: Examples include an adalimumab product (Humira, biosimilars), Cimzia, an infliximab IV product (Remicade, biosimilars), Zymfentra, Entyvio (IV or SC), Skyrizi (IV or SC), Stelara (IV or SC). - Please note: Each biosimilar tried from the same chemical would only count as a trial of one product. ☐ Yes ☐ No

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

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

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

V121324