

TYSABRI

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:			
Provider First Name:		Provider Last Name:			
Provider Phone:		Provider Fax:		Provider NPI #:	
Patient Name:		Patient UPMC Health Plan ID Number:		Patient Age:	
Patient DOB:					
Strength:	Frequency:	Qty Dispensed:	Diagnosis:	Date of diagnosis:	
<input type="checkbox"/> New medication		If ongoing, provide date started:		If medication is ongoing, Did member show improvement /stabilization while on therapy?	
<input type="checkbox"/> Ongoing medication				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate place of administration?		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility		Please indicate how medication will be billed:	
Please provide facility/provider name and address:				<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____	
				<input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

MEDICAL HISTORY

Is the prescribing physician registered with the TOUCH™ Prescribing program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member currently have or have a past history of progressive multifocal leukoencephalopathy (PML)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member currently on immunosuppressive or immunomodulatory therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list: _____	
Is the member immunocompromised?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please describe contributing medical condition: _____

Please choose from below the medications previously tried and failed: Please complete for New Starts Only

Medication Trial / Previous Therapy	Date of Therapy		Strength	Frequency	List Adverse Reactions / Side Effects / Reason For Discontinuing
	Start date	End date			
For Multiple Sclerosis					
<input type="checkbox"/> Avonex					
<input type="checkbox"/> Betaseron					
<input type="checkbox"/> Copaxone					
<input type="checkbox"/> Rebif					
For Crohn's Disease					
<input type="checkbox"/> Aziathioprine					
<input type="checkbox"/> 6-mercaptopurine					
<input type="checkbox"/> Cimiza					
<input type="checkbox"/> Humia					
<input type="checkbox"/> Remicade					
<input type="checkbox"/> Other (please list):					

Please provide any additional information which should be considered in the space below:
