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 DOB:**	**Patient Age:**

Strength:	**Frequency:**	**Qty Dispensed:**	**Diagnosis:**	**Date of diagnosis:**

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member show improvement /stabilization while on therapy?**	❑**Yes** ❑**No**

Please indicate place of administration?	❑Physician's Office ❑Hospital/Facility
Please provide facility/provider name and address:	

Please indicate how medication will be billed:

❑ Billed directly by the provider via JCODE
Provide JCODE:_____

❑ Billed by a pharmacy and delivered to the provider

❑ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Is the prescribing physician registered with the TOUCH™ Prescribing program?	❑ **Yes** ❑ **No**
Does the member currently have or have a past history of progressive multifocal leukoencephalopathy (PML)?	❑ **Yes** ❑ **No**
Is the member currently on immunosuppressive or immunomodulatory therapies?	❑ **Yes** ❑ **No**

If yes, please list:_____

Is the member immunocompromised?	❑ **Yes** ❑ **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					
❑**Avonex**					
❑**Betaseron**					
❑**Copaxone**					
❑**Rebif**					
For Crohn's Disease					
❑**Aziathioprine**					
❑**6-mercaptopurine**					
❑**Cimiza**					
❑**Humia**					
❑**Remicade**					
❑**Other (please list):**					

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