TYSABRI (NATALIZUMAB) [PREFERRED] PRIOR AUTHORIZATION FORM







(form effective 1/3/2022)

Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST	INFORMATION						
□ New request □ Renewal request □ Total # pages: Name of office contact:							
Contact's phone number:	100						
PATIENT INFORMATION	1						
Patient name:			Patient ID #:			D	OB:
Street address:		Apt. #:		City/state	e/zip:		·
PRESCRIBER INFORMATION							
Prescriber name:			Specialty:				
State license #:	NPI:			MA Provider ID #			
Street address:		e #: City/state/zip:					
Phone:			Fax:				
CLINICAL INFORMATION							
Medication requested: Tysabri (natalizumab) 300 n	ng/15 ml			Quantity:	via	ıls	Refills:
Directions: ☐ 300 mg SQ every 4 weeks ☐ other	· ·			-			Dx code (<u>required</u>):
Diagnosis: ☐ relapsing multiple sclerosis – Submit (documentation of diagnosis and dia	isease pa	attern.				
☐ moderately to severely active Crohn's						_	
other:					· · · · · · · · · · · · · · · · · · ·		
PHARMACY INFORMATION (Prescri				ispense	the medication	if ap	oplicable):
Deliver to: Patient's Home Physician's Office Pharmacy Phone #:	e 🗆 Patient's Preferred Pharma		e: Pharmacy Fax	, 4.			
□ I acknowledge that the patient agrees with the ph	armacy chosen for delivery of this			. #.			
				ATION	(if a muli a a la la).		
HCPCS (HEALTHCARE COMMON PROTECTION Treatment setting: Infusion Center Infusio			tient Facility	AHON	(II applicable):		
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Facility name:							
Facility name: J-code:	·		Facility NPI: Number of ur	nits:		Date	of service (MM/DD/YYYY):
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