

**Neighborhood Health Plan of Rhode Island
Prior Authorization Request Form
Tysabri® (natalizumab)**

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Tysabri (natalizumab) Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required)
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)

Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

ASSESSMENT OF BENEFIT NEED:

INDICATIONS FOR USE

	YES	NO
1) HAS THE PATIENT BEEN DIAGNOSED WITH MULTIPLE SCLEROSIS (MS)?	<input type="checkbox"/>	<input type="checkbox"/>
2) DOES THE PATIENT HAVE A RELAPSING FORM OF MS?	<input type="checkbox"/>	<input type="checkbox"/>
3) HAS THE PATIENT EXPERIENCED A RELAPSE WITHIN THE LAST 12 MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>
4) DOES THE PATIENT HAVE A CHRONIC PROGRESSIVE FORM OF MS?	<input type="checkbox"/>	<input type="checkbox"/>
5) HAS THE PATIENT FAILED A TRIAL OF AVONEX, BETASERON, REBIF OR COPAXONE?	<input type="checkbox"/>	<input type="checkbox"/>
6) DOES THE PATIENT HAVE KNOWN HYPERSENSITIVITY TO TYSABRI OR ANY OF ITS COMPONENTS?	<input type="checkbox"/>	<input type="checkbox"/>

BENEFIT TERMS UPON APPROVAL:

INITIAL APPROVAL WILL BE FOR 3 MONTHS AT WHICH TIME PATIENT SHOULD BE EVALUATED FOR RESPONSE/TOXICITY TO THERAPY. IF PATIENT IS RESPONDING TO THERAPY, AN ADDITIONAL 6 MONTHS WILL BE APPROVED.

All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI:** _____ **Date:** _____

**Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945**