

<input type="checkbox"/> Preferred drug accepted. New verbal order authorized.
<input type="checkbox"/> Preferred drug rejected by physician.

**Health New England  
Medication Request Form (MRF /Prescription Request  
Tysabri® (natalizumab)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

- Prior Authorization Only
- Prior Authorization and Drug Delivery Request

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Tysabri®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

**J-Code: Q4079, unit = 1mg**

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)		Physician Information (all required)	
<b>Patient Name:</b>		<b>Physician Name:</b>	
		<b>Specialty:</b>	
<b>Patient Cell Phone #:</b> (     )     -		<b>NPI #:</b>	
<b>Patient HNE ID#:</b>		<b>HNE Provider #:</b>	
<b>Patient Date of Birth:</b>		<b>DEA #:</b>	
<b>Allergies:</b>		<b>Telephone #:</b> (     )     -	
<b>Diagnosis:</b>		<b>Fax # (required):</b> (     )     -	
Drug Information			
<b>Preferred Drug/Strength/Form:</b> <input type="checkbox"/> Copaxone <input type="checkbox"/> Rebif			
<b>Requested Drug/Strength/Form:</b>			
<b>Dose, Directions, and length of treatment (please be specific):</b>		<b>Quantity (per month):</b>	<b>Refills:</b>
<b>Physician Signature:</b>		<b>Date:</b>	
<b>Indication:</b>			
<input type="checkbox"/> Monotherapy for relapsing forms of multiple sclerosis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Other (please describe): _____			
<b>Documentation of Medical Necessity (check all that apply):</b>			
<input type="checkbox"/> The prescribing physician is a neurologist AND a member of the TOUCH program <input type="checkbox"/> The infusion facility is part of the TOUCH program <input type="checkbox"/> The patient does NOT have a diagnosis of progressive multifocal leukoencephalopathy (PML) <input type="checkbox"/> The patient has tried and failed at least one of the following: Avonex, Betaseron, Rebif, Copaxone or Novantrone <input type="checkbox"/> The latest MRI shows continued CNS lesion progression (date of latest MRI is _____), or has highly active RRMS with a poor response to both beta interferons and glatiramer, or intolerance to immunomodulators <input type="checkbox"/> Other pertinent history: _____			