

Office Administration Request Form for Tysabri® (Natalizumab)

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**.

Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

To speak to a representative, call **800-578-0898**. *Form must be completed for processing*



Patient Name: _____ Member ID#: _____

Address: _____ Apt # or Suite #: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____ Birthdate: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____ City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____ LTC member Yes No, Date Admitted _____

Medical Condition:	<input type="checkbox"/> Relapsing/Remitting MS	<input type="checkbox"/> Crohn's Disease
	<input type="checkbox"/> Primary Progressive MS	<input type="checkbox"/> Secondary Progressive MS
	<input type="checkbox"/> Chronic – Progressive Relapsing	
	<input type="checkbox"/> Other: _____	

Is the member currently enrolled in the TOUCH™ program (please check): Yes No

Does the member have a history of progressive multifocal leukoencephalopathy (PML): Yes No

Start of Date of Treatment: _____ Dose: _____ SIG: _____ Refills: _____

Previous Medication Treatment History

Medication	Start/End Date	Directions/Frequency	Reason for discontinuing treatment
Avonex® (Interferon beta-1a)			
Betaseron® (Interferon beta-1b)			
Rebif® (Interferon beta-1a)			
Copaxone® (Glatiramer acetate)			
Remicade® (Infliximab)			
Humira® (Adalimumab)			

Medical Reasons for selecting Tysabri® instead of another treatment option: (Attach additional information if necessary):

For a diagnosis other than Crohn's Disease or Multiple Sclerosis: Rationale for choosing this treatment, please include all applicable documentation: _____

