# TYSABRI (Natalizumab) J2323 Request

**Please Fax Response To:** 1-866-668-1214  
**Medical Request Coordinator**

Please provide the information below, PRINT your answer, attach supporting documentation; and sign, date and return to our office as soon as possible to expedite this request. PLEASE PRINT!

*Without this information, the request may be denied in 30 days.*

<table>
<thead>
<tr>
<th>DATE OF REQUEST</th>
<th>CLIENT NAME</th>
<th>PROVIDERONE CLIENT ID</th>
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</thead>
<tbody>
<tr>
<td>PRESCRIBER’S NAME</td>
<td>BILLING PROVIDER NPI</td>
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<tr>
<td>TELEPHONE NUMBER</td>
<td>FAX NUMBER</td>
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<tr>
<td>DRUG / STRENGTH / DOSE</td>
<td>Procedure/HCPC Code: <strong>J2323</strong></td>
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**Note:** Tysabri® is only covered as monotherapy for treating MS (Multiple Sclerosis) and Crohn’s Disease.  
*DSHS requires a Neurologist or a Physician’s Assistant or ARNP working with a Neurologist to prescribe Tysabri for MS and a Gastroenterologist to prescribe Tysabri for Crohn’s.*

1. What is the confirmation date for the MS/Crohn’s diagnosis: ____________ Please attach supporting objective clinical documentation.

2. Client must have tried and failed other drugs for MS/Crohn’s. What alternative medication(s) have been tried?  
What were the outcomes? How long was the trial?

3. If no other medication has been tried please explain why not?

4. Client’s with MS must have an MRI before starting Tysabri® treatment. Date of MRI? ____________

5. Please confirm whether the client is immunocompromised.  
   ☐ Yes  ☐ No

   **If yes, Tysabri is contraindicated.**

6. Are you registered with the Tysabri TOUCH (MS or CD) Prescribing Program?  
   ☐ Yes  ☐ No

7. Is the client enrolled in the TOUCH Prescribing Program?  
   ☐ Yes  ☐ No

8. Additional Information:

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<tr>
<th>PRESCRIBER SIGNATURE</th>
<th>PRESCRIBER SPECIALTY</th>
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A typed and completed General Authorization for Information form, DSHS 13-835, must be attached to your request in order to be processed by the Department.