**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>
</tr>
</thead>
<tbody>
<tr>
<td>PRESCRIBER’S NAME</td>
<td>BILLING PROVIDER NPI</td>
<td></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: J2323</td>
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**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  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.