NEBRASKA MEDICAID & LONG-TERM CARE
TYSABRI (Natalizumab) Prior Authorization Form

Patient' Name_____

Medicaid ID _____ Patient's date of birth _____

Physician (please print) _____Specialty √ ____Neurology ____ GI

TOUCH program enrolled? √ ___ yes ____no

Physician's Address _____

Physician's Phone ( ) _____ Physician's Fax Number ( )_____

TYSABRI is covered for Multiple Sclerosis and Crohn's disease. Prescribing physician and patient must be enrolled with TOUCH prescribing program. The provider has the responsibility to verify a client's eligibility and other limitations that apply to a specific client.

√ ____ Initial dose: Documentation to include but not limited to:

1. Supporting clinical documentation for medical necessity including diagnosis and severity,
2. Previous therapies tried and patient response to each (list medications).
3. Copy of TOUCH program authorization for the client.

√ ____ Subsequent request: Documentation to include but not limited to:

1. Supporting clinical documentation for medical necessity including last progress note indicating patient response to therapy and MRI results, if done.
2. Copy of TOUCH program authorization form for client.

Any additional physician comments:

Ordering Physician's Signature _____ Date _____

Submit this form and medical records to Nebraska Medicaid Physician's Program Specialist by:
FAX: (402) 471-9092; EFAX to (402) 472-1104; or Mail at P.O. Box 95026, Lincoln, NE 68509

DO NOT WRITE BELOW THIS LINE-MEDICAID USE ONLY:

_____ Approval for Ongoing Therapy for 6 months from _____ to _____
_____Denied/ Rationale _____
_____Unable to determine _____

Signature _____Date _____
Program Specialist