

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Diagnosis	<input type="checkbox"/> Relapsing form of Multiple Sclerosis <input type="checkbox"/> Moderate-to-Severe Crohn's Disease <input type="checkbox"/> Other (please state): _____
Clinical Consideration	<p>For indication of MS</p> <input type="checkbox"/> Disease progression despite therapy with Avonex, Betaseron, Copaxone, or Rebif? If yes, explain (duration of therapy): _____ Tysabri will only be approved as monotherapy for MS, is patient currently taking interferon based therapy or other immunosuppressive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ <input type="checkbox"/> Patient and Prescriber enrolled in TOUCH program
Physician Specialty	<p>For indication of Crohn's Disease</p> <input type="checkbox"/> Inadequate response to conventional therapies If yes, which therapies have been tried? _____ <input type="checkbox"/> Patient and Prescriber enrolled in CD TOUCH prescribing program
Physician Specialty	<input type="checkbox"/> Prescribed by a Neurologist (MS) <input type="checkbox"/> Other (please state): _____ <input type="checkbox"/> Prescribed by a Gastroenterologist (Crohn's)
Supporting Documentation	<p>Diagnosis: ICD-9 Code #/ Description / J Code (required): _____</p> <p>Please attach a copy of the prescription or provide ALL of the information below: Tysabri® (natalizumab)</p> Strength _____ Sig _____ Qty _____ Refills _____
	<p>Please attach all relevant medical records and test results. Incomplete forms will not be processed.</p>

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP
3

Prescriber Signature _____
Date

STEP
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
970-248-5034**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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