

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"/> Prescribed by a Gastroenterologist (Crohn's) <input type="checkbox"/> Other (please state): _____ |
| Supporting Documentation | <p>Diagnosis: ICD-9/10 Code #/ Description / J Code (required):</p> <p>Please attach a copy of the prescription or provide ALL of the information below: Tysabri® (natalizumab)</p> <p>Strength _____ Sig _____ Qty _____ Refills _____</p> <p><i>*Please attach all relevant medical records and test results*</i></p> <p>We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.</p> |

STEP
3

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

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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