PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-800-734-4664

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Date: ____ / ____ / ____

Cardholder Name: ________________________ / _____ / ________________________
First MI Last

Patient Name: ________________________ / _____ / ________________________
First MI Last

Patient Address: ____
Street

____
City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____ R [| | | | | | |]
Cardholder Identification Number

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in my care, to release to the Blue Cross and/or Blue Shield Plan any medical information which they deem necessary to adjudicate this claim.

________________________________ ( ) ________________________
Cardholder Signature Patient Area Code and Phone Number

PHYSICIAN COMPLETES

NAME OF DRUG TO BE USED: **TYSABRI®**

- ICD – 9 – CM codes (**Mandatory**): ____________________________
- Diagnosis: ____

FOR INTERNAL USE ONLY

Please indicate the type of Multiple Sclerosis:

Relapsing/ Remitting _______

Relapsing/Progressive **or** Secondary /Progressive _______

Chronic/Progressive **or** Primary/ Progressive _______

Please select all that apply. Patient:

1. Is enrolled in, and meets, all the conditions of the TOUCH Prescribing Program. ______
2. Is not taking any antineoplastic, immunosuppressant, or immunomodulating agents. ______
3. Cannot tolerate or has not responded adequately to other treatments for MS. _____
4. Agrees to contact their prescriber if new or worsening symptoms develop. ______

The information provided on this form will be used to determine the provision of health care benefits under a U.S. federal government program, and any falsification of records may subject provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

________________________________ (______) ________________ (______) ________________
Physician Name (Print Clearly) Phone Fax

________________________________ ________________________ __________ __________
Street Address City State Zip

________________________________ ________ / ________ / ________
Physician Signature Date