

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs kg  
Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Patient Preferred Location: \_\_\_\_\_

<ICD 10 CODE REQUIRED>

## DIAGNOSIS & CLINICAL INFORMATION

**ICD 10 Code**

G35 Multiple Sclerosis

Other: \_\_\_\_\_

Product information suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of therapy.

**REQUIRED:** Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.  
**LAB RESULTS:** Include anti-JCV antibodies test results within last 6 months. (Patients who are anti-JCV antibody positive will require documentation from prescriber that risks/benefits have been discussed.)

## PRESCRIPTION

**Pre-Medications**

Acetaminophen: 650 mg PO

Cetirizine: 10 mg PO

Diphenhydramine: 25 mg PO

Diphenhydramine: 25 mg IVP

Famotidine: 20 mg PO

Methylprednisolone: 125 mg SIVP

Other: \_\_\_\_\_

**Tysabri (natalizumab)**

**Loading Dose:**

IV: Infuse 300 mg in 100 ml of 0.9% Sodium Chloride over at least 60 minutes every 4 weeks (no less than 28 days) for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Post Treatment Observations:** The patient is observed for 1 hour following the first 12 infusions and 15 minutes following the 13th and subsequent infusions.

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Supervising Physician: \_\_\_\_\_ (If Applicable)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_