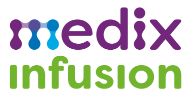

Tysabri Order Form
(natalizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ______________________________

DOB: ______________ Phone: ______________ Sex: M F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

G35 Multiple Sclerosis
K50.00 Crohn's Disease, Small Intestine
K50.10 Crohn's Disease, Large Intestine
K50.80 Crohn's Disease, Small and Large Intestine
K50.90 Crohn's Disease, Unspecified
Other: ______________________________

Patient Status:

New to therapy
Continuing therapy (date of last dose ____________)

Weight: ____________ lb kg Height: ____________

Allergies: ______________________________

PRESCRIPTION

Pre-Medications

Acetaminophen: 650 mg PO
Cetrizine: 10 mg PO
Diphenhydramine: 25 mg PO
Diphenhydramine: 25 mg IVP
Famotidine: 20 mg PO
Methylprednisolone: 125 mg SIVP
Other: ______________________________

TSYABRI (natalizumab)

300 mg IV every 4 weeks for 1 year

Is the patient on any other disease modifying therapy? **Yes** **No**

Is yes, please note therapy and last dose:

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

Other Orders: ______________________________

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
- Patient enrolled in TOUCH program; prescriber is a TOUCH authorized provider

Supporting/labs diagnostics:
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.

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

Signature: ______________________________

NPI #: ______________________________ Date: ______________

Supervising Physician (if applicable): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Contact Name: ______________ Phone: ______________ Fax: ______________