medix infusion

Tysabri Order Form
(natalizumab)

FAX TO: 972.499.9210

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

Is the patient on any other disease modifying therapy? Yes No
If yes, please note therapy and last dose: ____________

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

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

Comments:

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PRESCRIBER INFORMATION

Prescriber Name: ____________ Signature: ____________

Date: ________ NPI #: ____________ Specialty: ____________

Supervising Physician: ____________ (If Applicable)

Address: ____________ City: ____________ State: ________ Zip: ________

Contact Name: ____________ Phone: ____________ Fax: ____________ Email: ____________