medix infusion

Natalizumab® Order Form

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

ICD 10 Code (Required)

☐ G35.A Relapsing-Remitting Multiple Sclerosis
☐ G35.C1 Active Secondary Progressive Multiple Sclerosis
☐ G37.9 Demyelinating Disease of Central Nervous System, Unspecified
☐ K50.80 Crohn's Disease, Small and Large Intestine
☐ K50.90 Crohn's Disease, Unspecified
☐ Other: _____

☐ New to Therapy
☐ Continuing Therapy (date of last dose _____)

Medication Order

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetrizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: _____mg
☐ Other:_____

TSYABRI (natalizumab) or BIOSIMILAR
as Dictated by Patient's Insurance*
***Medix Infusion will determine appropriate product based upon benefit investigation OR**
☐ Natalizumab Product _____ (**Do Not Substitute**)

Lab Orders
Requested Add'l Lab Orders:
_____
_____

Loading Dose (SELECT ONE)
☐ **IV:** 300 mg every 4 weeks for 1 year
☐ **IV:** 300 mg IV every _____ weeks for 1 year

Lab Frequency: _____every _____weeks

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

Comments: _____

Required Clinical Documentation

- **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 or Tyruko REMS dependent on drug product; prescriber is authorizing provider for drug specific REMS portal as well**

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

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.

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____