



INFUSION ORDERS-TYSABRI (NATALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>
 Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
<input type="checkbox"/> Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
<input type="checkbox"/> Primary Progressive Multiple Sclerosis	ICD 10 Code: G35
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Pregnancy Test (if applicable) <input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM <input type="checkbox"/> Anti-JCV antibodies test result
If MS, current MS treatment and end of current therapy date:	
Is your patient currently enrolled in the TOUCH (FDA REMS) program? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION ORDERS**	
Dosing	<input type="checkbox"/> Tysabri 300mg IV every 4 weeks <input type="checkbox"/> Tysabri 300mg IV every _____ weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO, 30-60 minutes prior to infusion <input type="checkbox"/> Diphenhydramine 25mg PO, 30-60 minutes prior to infusion <input type="checkbox"/> Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion <input type="checkbox"/> Other: _____

OTHER TESTING (Optional)
<input type="checkbox"/> Urine pregnancy test prior to first infusion

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164

