

(natalizumab)

TYSABRI infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐
☐ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

- ☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

DIAGNOSIS Please provide ICD-10 code

- ☐ _____ Multiple Sclerosis
☐ _____ Crohn's Disease
☐ _____ (other)

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ (other)
- ☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ (other)

TYSABRI ORDERS

DOSAGE

- ☒ 300mg IV
☐ Other _____

FREQUENCY

- ☒ every 4 weeks for _____ treatments
☐ Other _____

LAST DOSAGE OF:

- ☐ Avonex ☐ Betaseron ☐ Rebif

PATIENT WEIGHT

_____ lbs.

_____ kg

Date of last dose: _____

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____