*Boca Raton*
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

# TYRUKO (natalizumab-sztn) ORDER FORM

**Date:** _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | Phone: | DOB: SEX: M ☐ F ☐ |
| ☐NKDA Allergies: | | Weight lbs/kg: |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Physician Name*: | Practice Name: | |
| Address: | Office Contact Name: | Office Contact #: |
| Phone: Fax: | Email (for updates): | |

## REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

TYRUKO : is an integrin receptor antagonist indicated for treatment of:

☐ **Multiple Sclerosis (MS)**
TYRUKO is indicated as monotherapy for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

☐ **Crohn's Disease (CD)**
TYRUKO is indicated for inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn's disease with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-α. ***Important Limitations:*** In CD, TYRUKO should not be used in combination with immunosuppressants or inhibitors of TNF-α.

## DIAGNOSIS *Please provide ICD-10 code*

☐ _____
☐ _____

## PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000 MG ☐other _____
☐ Solumedrol 125mg IV ☐other _____
☐ Benadryl ☐25mg ☐50mg ☐other _____ ☐IV ☐PO
☐ Benadryl 50 mg ☐or PO
☐ Medication _____ Dose _____Route _____
☐ _____ *(other)* ☐ _____ *(other)*

## NOTE:

## WARNINGS AND PRECAUTIONS

https://www.pi.amgen.com/-/media/Project/Amgen/Repositorypi-amgen-com/Riabni/riabni_pi_english.pdf

## TYRUKO ORDERS

### PATIENT WEIGHT

_____ lbs.
_____ kg

### DOSAGE

☐ 300mg IV
☐ Other_____

### FREQUENCY

☐ Every 4 weeks for _____ month
☐ Other_____

### LAST DOSAGE OF

☐ Avonex ☐ Betaseron ☐Tysabri
Date of last dose:_____

### LAB DRAW REQUEST

☐ Labs: _____
☐ Freq: _____

## REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Recent labs to include **CBC, CMP, JCV and Hep B surface antigen** and any other recent labs

_____ **Please Confirm Provider is registered in CD or MS Tyruko REMS**

_____ Current Medication List

_____ Other

**ORDERING PROVIDER**

Signature **X** _____ Date _____ **NPI**_____

Provider _____ Phone _____ Fax _____