

Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Princeton / Somerset
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



TYRUKO (natalizumab-sztn)

ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/> 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:

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

WARNINGS AND PRECAUTIONS

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

ORDERING PROVIDER

Signature **X** _____ Date _____

NPI _____

Provider _____ Phone _____ Fax _____