

(natalizumab)

TYSABRI infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

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

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS Please provide ICD-10 code

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

PRE-MEDICATION

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

TYSABRI ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE

- ☐ 300mg IV
☐ Other _____

FREQUENCY

- ☐ Every 4 weeks for _____ treatments
☐ Other _____

LAST DOSAGE OF

- ☐ Avonex ☐ Betaseron ☐ Rebif
Date of last dose: _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____