

TYSABRI

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

PATIENTReferral Status: ☐ New ☐ Updated ☐ RenewalName: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICALDiagnosis: ☐ G35.A (Relapsing-Remitting Multiple Sclerosis) ☐ G35.C1 (Active secondary Progressive MS)☐ K50.____ (Crohn's Disease) ☐ Other: _____Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ inTOUCH enrollment/authorization complete: ☐ Yes ☐ No Anti-JCV Antibody: ☐ Positive ☐ NegativeCBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No Date: _____ Index _____**TREATMENT****TYSABRI (natalizumab)**

Route: Intravenous infusion

Dose: ☐ 300mg

Frequency:

☐ Every 4 weeks☐ Other: _____**Premedication Protocol:** (Not Usually Indicated)☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____