

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

G35.A Relapsing-Remitting MS (RRMS) G35.C2 Non-Active Secondary Progressive MS (SPMS)

G35.C0 Secondary Progressive MS (SPMS), unspecified G35.D Multiple Sclerosis, unspecified

G35.C1 Active Secondary Progressive MS (SPMS)

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information
- List of Medications
- Tried & Failed Therapies
- Most Recent History & Physical
- Touch Enrollment
- Anti-JCV antibodies results

MEDICATION ORDER

Tysabri®(natalizumab) 300mg IV in 100ml NS over 1 hour every 4 weeks (no less than every 28 days)

Tysabri® (natalizumab) 300mg IV in 100ml NS over 1 hour every: _____

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

LAB ORDERS

LAB: _____ FREQUENCY: _____

Patient to be observed for 60 minutes following the first 12 infusions. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN

PRE-MEDICATIONS

PO

- Acetaminophen: 650 mg
- Cetirizine: 10 mg
- Diphenhydramine: 25 mg

IV

- Methylprednisolone: 125 mg
- Diphenhydramine: 25 mg

OTHER: _____ PO IV