

TYSABRI (NATALIZUMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- ☐ Patient's **TOUCH** authorization
- ☐ Last MRI

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis: ☐ Multiple Sclerosis (ICD-10: _____) ☐ Crohn's Disease (ICD-10: _____)

J Code: J0202

TYSABRI ORDERS

Tysabri Intravenous Dose: 300mg infused over 60 mins

Frequency: ☐ Once a day, every 4 weeks X _____ doses

Protocol Pre-medication Orders: ☐ Tylenol 1000mg PO ☐ Antihistamine 25mg PO

****Date of last** ☐ Rebif ☐ Betaseron ☐ Avonex **Dose:** _____ **Date:** _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	