

Tysabri® Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

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

Phone #: _____ Cell Alternate Phone #: _____ Cell

Height: _____ in/ft **Weight:** _____ lbs/kg Date weight recorded: _____ **Last 4 of SSN#** _____

Allergies: _____ NKDA

Diagnosis Information: Multiple Sclerosis; Relapsing G35

Other Diagnosis/ICD10 code _____

Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? Yes No HTN? Yes No Cardiac History? Yes No Difficulty Breathing? Yes No

Requires Oxygen? Yes No Confusion /Disorientation? Yes No Neuro History? Yes No

Date of Negative TB test: _____ **Date of negative JCV test:** _____

Tysabri (natalizumab)®: J2323 **Provider Reviewed FDA/REMS recommendations**

Dose: 300mg IV over 1 hour every 28 days for _____ months

Is patient enrolled in the TOUCH program? Yes No

Pre-Medications: Patient to provide and take 30 minutes prior to infusion

Benadryl 25 MG PO x1 Benadryl 50 mg PO x1

Acetaminophen 325 mg PO x1 Acetaminophen 650 mg PO x1

Other Pre-medication: _____

<p>Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5ml: Qty 3</p> <p>PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion</p>	<p>Supplies: (please strike through if not required)</p> <p>Administration Supplies (A4222) – 1 per infusion</p> <p>Catheter Care Supplies (A4221) – 1 per week</p> <p>Infusion Pump (E0781)</p> <p>Nursing services to administer</p>
--	---

For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St GA Zip: _____

Printed Name: _____ Contact Name: _____

Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.