

### PATIENT DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
 Allergies See List NKDA City, State, Zip: \_\_\_\_\_  
 Weight: \_\_\_\_\_ kg lbs Height: \_\_\_\_\_ in cm Email: \_\_\_\_\_

### PRIMARY DIAGNOSIS

G35.A (RRMS) G35.B0 (PPMS-NOS) G35.B1 (Active PPMS) G35-B2 (Non-active PPMS)  
 G35.C0 (SPMS-NOS) G35.C1 (Active SPMS) G35.C2 (Non-Active SPMS) G35.D (MS-NOS)  
 Other: \_\_\_\_\_

### PRESCRIPTION

#### Tysabri (natalizumab)

Tysabri 300mg IV every 4 weeks

Other: \_\_\_\_\_

Has patient received any doses of this medication in the past? Yes No

Refill x 12 months unless otherwise noted: \_\_\_\_\_

### REQUIRED DOCUMENTATION

- Insurance Card
- Medication List
- Anti-JCV antibody test
- H&P
- Most recent labs
- TOUCH enrollment
- Patient Demographics

### ANCILLARY ORDERS

#### ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol (*See aiscaregroup.com for detailed policy*)

Other: Please fax other reaction orders if checking this box

#### PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: There are no recommended standard pre-meds for Tysabri

Provider Prescribed: \_\_\_\_\_

#### LINE CARE ORDERS

Start PIV/Access CVC Flush device per Advanced Infusion Care Centers' protocol (*See aiscaregroup.com for detailed policy*)

Other Flush Orders: Please fax other line care orders if checking this box

#### LAB ORDERS—PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_

NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*