

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 ORDERSStart 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.