Tysabri

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Notes, Insurance Information, TOUCH Program Authorization, JC Virus Result, Tried & Failed Medication list

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G35 ☐ K50.90 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ Verify patient is enrolled and authorized in TOUCH program
- ☑ JC Virus Results (list results & attach clinicals)

  _____
- ☑ Tried & Failed Medications:

  _____

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV
- ☐ Cetirizine ☐ 10mg PO
- ☐ Loratadine ☐ 10mg PO
- ☐ Other: _____

  Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other: _____
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☑ Tysabri Intravenous Infusion

  Dose: 300mg/15mL solution in a single dose vial for dilution

  Frequency:
  - ☐ Every 4 weeks
  - ☐ Other: _____
- ☐ Monitor patient for one hour after the completion of the first 12 infusions
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____

  (if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print)	Provider Signature	Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***