

Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order:**

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, JC Virus Results

## PATIENT INFORMATION

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

Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): ☐ G35.A ☐ G35.C1 ☐ 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)  
\_\_\_\_\_

## 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.

## PRE-MEDICATION ORDERS

*Pre-Medications not usually indicated.*

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ Other: \_\_\_\_\_
- ☐ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

- ☒ Tysabri Intravenous Infusion
- ☒ Dose: 300mg  
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.