

# Tysabri

(Or other natalizumab products as required by the patient's health plan)



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  G37.9 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

- Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions
- 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 \_\_\_\_\_
- Stratify JCV Antibody  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

- Natalizumab Intravenous Infusion
- Dose: 300mg  
Frequency: \_\_\_\_\_
- Every 4 weeks
- Other: \_\_\_\_\_
- 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.