

TYSABRI ORDER FORM

Date: _____ Patient Name: _____ Date of Birth: _____	ICD-10 Code: _____ Allergies: _____ Weight: _____ lbs OR _____ kg
Therapy Status	Provider Information
<input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

<input type="checkbox"/> Tysabri	<input type="checkbox"/> Tysabri 300mg IV every four weeks to be infused over a minimum of 60 minutes per protocol. <input type="checkbox"/> Tysabri 300mg IV every _____ weeks to be infused over a minimum of 60 minutes per protocol.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<p><i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i></p> <p style="text-align: center;">✓ JCV Antibody</p>
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PRE-MEDICATIONS

<p><u>Oral</u></p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><u>IV</u></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____ _____ Prescriber Name	Substitution Allowed: _____ _____ Prescriber Name
_____ Date	_____ Date