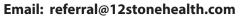
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

**Direct Phone: (844) 893-0012** 





TYSABRI ORDER FORM						
Date: ICD-10 Code:_		ICD-10 Code:			Therapy Status	
Patient Name:		Allergies:		☐ New Start		
Date of Birth:		Weight:kg		☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION						
Ordering Provider: Provider Fax:						
Provider NPI:				Provider Address:		
Provider Phone:						
MEDICATION ORDER						
WIEDICATION ORDER						
Tysabri	<ul> <li>□ Tysabri 300mg IV every four weeks to be infused over a minimum of 60 minutes per protocol.</li> <li>□ Tysabri 300mg IV every weeks to be infused over a minimum of 60 minutes per protocol.</li> </ul>		Refill of sig	Refills for one year from date of signature unless indicated below.  Refills		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:   Baseline JCV Antibody prior to first infusion
PRE-MEDICATIONS						
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg40mg600mg         □ Ondansetron:4mg8mg         □ Other:				IV   □ Dexamethasone:4mg8mg   □ Diphenhydramine:25mg50mg   □ Famotidine:20mg40mg   □ Methylprednisolone: 125mg   □ Hydrocortisone: 100mg   □ Ondansetron:4mg8mg   □ Other:		
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**  By signing below, I certify that the above therapy is medic  By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my to payors with respect to this patient and prescription order. This enrollment				y designated agent in submitting prior authorizations and other clinically required information		
Prescriber	Signature	 Date		Prescriber Sigr	nature	 Date