COMMUNITY HEALTH INTERVENTIONS SPECIALTY CLINIC

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INFUSION ORDERS-TYSABRI (NATALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE	
☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Pregnancy Test (if applicable)	☐ Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM
☐ Tried and Failed therapies	☐ Anti-JCV antibodies test result
If MS, current MS treatment and end of current therapy date:	
Is your patient currently enrolled in the TOUCH (FDA REMS) program?	☐ Yes ☐ No

MEDICATION ORDERS**		
Dosing	☐ Tysabri 300mg IV every 4 weeks ☐ Tysabri 300mg IV every _____ weeks	☐ Pt has had 12 infusions and does not need post infusion observation
Refills: ☐ X **6 months**	☐ X 1 year	☐ _____doses

PREMEDICATIONS
☐ Acetaminophen 650mg PO, 30-60 minutes prior to infusion
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to infusion
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion
☐ Other: _____

OTHER TESTING (Optional)
☐ Urine pregnancy test prior to first infusion

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: jeff@eastoninfusion.com or call 728-777-5546

Fax completed form and all documentation to **(561) 709-8626**

All information contained in this form is strictly confidential and will become part of the patient's medical record.