TYSABRI (natalizumab) ORDERS

Please type or print. Complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Call 817-553-1325 with any questions. Thank you for your referral and allowing us to partner with you in the care of your patient.

Patient: _____ __ DOB: _____
Weight: _____ lbs Allergies: _____
Diagnosis/ICD10: Multiple Sclerosis/G35

Prior to the infusion, please obtain and send results with your order to 817-553-1393:

- This completed order form
- Patient demographics and insurance cards (front and back)
- All office notes, labs and scans supporting diagnosis/ICD-10
- Previous medications taken and date of last dose.
- Last JCV titer.

Prescription: (Please check appropriate box)** Order expires in one year.

- Start Peripheral IV Saline lock.
- Flush IV line with 3 to 10ml 0.9% Sodium Chloride before and after IV medication administration.

- Pre-medications: _____
- **TYSABRI** 300 MG IV given over 1 hour. Observe patient one hour after Tysabri infusion for first 12 infusions only. Infuse every 28 days for 1 year.
- Lab orders: _____

Ordering Provider Information

Name _____
Address _____
_____
NPI # _____
Signed _____

Office Contact Information

Name _____
Phone ( ) _____-_____
Fax ( ) _____-_____
Email _____
Date _____ /_____ /_____