Tysabri (Natalizumab) Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs (JCV), and Tests (including last MRI) supporting primary diagnosis (ICD-10 below)
☐ Patient's TOUCH authorization
☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:
☐ Crohn's Disease (ICD-10 _____)
☐ Multiple Sclerosis (ICD-10 _____)

Tysabri Dose: ☐ 300 mg in 100 mL NS IV to be infused over 60 minutes

Frequency: ☐ every 4 weeks OR ☐ other: **Refill**: ☐ PRN x 1 year OR _____ times
_____

Patient may receive this medication in the home: ☐ Yes ☐ No

Date of last ☐ Rebif ☐ Betaseron ☐ Avonex Dose: _____ Date: _____ ☐ N/A

Protocol Pre-Medication Orders (optional):

☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO

☐ Diphenhydramine 25 mg PO OR ☐ Cetirizine 10 mg PO

Additional Pre-Medication Orders (optional):

☐ Other: _____

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed
☐ May use Burnham's Vital Care flush and catheter maintenance protocol

Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care
☐ May use Burnham's Vital Care anaphylaxis protocol

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		