

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:		

ALABAMA

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