Tysabri (natalizumab)

MIC | METRO INFUSION CENTER

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

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	
☐ Relapsing-Remitting multiple sclerosis	ICD-10 Code: G35.A
☐ Primary Progressive multiple sclerosis, unspecified	ICD-10 Code: G35.B0
☐ Active primary progressive multiple sclerosis	ICD-10 Code: G35.B1
☐ Non-active primary progressive multiple sclerosis	ICD-10 Code: G35.B2
☐ Secondary Progressive multiple sclerosis, unspecified	ICD-10 Code: G35.C0
☐ Active secondary progressive multiple sclerosis	ICD-10 Code: G35.C1
☐ Non-active secondary progressive multiple sclerosis	ICD-10 Code: G35.C2
☐ Multiple sclerosis, unspecified	ICD-10 Code: G35.D

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider	☐ Tried and Failed therapies
☐ Patient demographics AND insurance info	☐ Labs and Tests supporting primary diagnosis
☐ Clinical/Progress notes supporting primary dx	☐ 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 (if No, please enroll your patient)	

PREMEDICATION ORDERS

☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg

☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)

☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐100mg ☐ 125mg ☐ _____ mg

☐ Other:

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*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____

**(if not indicated order will expire one year from date signed)*

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

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

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

Modified 9/5/25