

Tysabri (natalizumab)/Biosimilar

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
<input type="checkbox"/> NKDA Allergies:	Weight (lbs / kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:	Next Due Date:	
PROVIDER INFORMATION		
Office Contact Name:	Office Email:	
Prescribing Providers Name:	Provider NPI:	
Office Phone Number:	Office Fax Number:	
DIAGNOSIS AND ICD 10 CODE		
<input type="checkbox"/> Relapsing-Remitting multiple sclerosis	ICD-10 Code:	G35.A
<input type="checkbox"/> Active secondary progressive multiple sclerosis	ICD-10 Code:	G35.C1
<input type="checkbox"/> Multiple sclerosis, unspecified	ICD-10 Code:	G35.D
<input type="checkbox"/> Crohn's Disease (please specify ICD 10 Code)	ICD-10 Code:	
REQUIRED DOCUMENTATION/Testing		
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance info <input type="checkbox"/> Clinical/Progress notes supporting primary dx	<input type="checkbox"/> Tried and Failed therapies <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Anti-JCV antibodies test result	
If MS, current MS treatment and end of current therapy date:		
Is your patient and provider currently enrolled in the FDA REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, please enroll)		
PREMEDICATION ORDERS		
<input type="checkbox"/> acetaminophen (Tylenol) PO <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg <input type="checkbox"/> diphenhydramine (Benadryl) PO / IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg (if route is not circled PO will be administered) <input type="checkbox"/> methylprednisolone (Solu-Medrol) IV <input type="checkbox"/> 60mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg <input type="checkbox"/> _____ mg <input type="checkbox"/> Other:		
MEDICATION ORDERS		
<input checked="" type="checkbox"/> Provider will select product (chosen based on patient's insurance coverage and availability)		
Dosing	<input type="checkbox"/> 300mg IV every 4 weeks <input type="checkbox"/> 300mg IV every _____ weeks	<input type="checkbox"/> Pt has had 12 infusions without evidence of hypersensitivity reaction no need to observe post infusion
Refills*: <input type="checkbox"/> None <input type="checkbox"/> X6 months <input type="checkbox"/> X1 year <input type="checkbox"/> Other: _____ <i>*(if not indicated order will expire one year from date signed)</i>		
OTHER TESTING (Optional) : <input type="checkbox"/> Urine pregnancy test prior to first infusion		

Physician Signature:

Date:

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