

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code
Required**

- Multiple Sclerosis, G35
- Crohn's Disease (K50.00-K50.919), ICD10 _____
- Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Tysabri® (natalizumab) <input type="checkbox"/> Patient is enrolled in TOUCH Prescribing Program	300 mg	<input type="checkbox"/> Infuse IV over 1 hour every 4 weeks x _____ months *Observe patient for 1 hour after completion of infusion. <input type="checkbox"/> If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD.

Is patient currently receiving therapy above from another facility?

Yes No

If yes, Facility Name: _____
 Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

- No premeds ordered at this time
- Acetaminophen 650mg PO Diphenhydramine 25mg PO
- Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP
- Other: _____

LAB ORDERS

- Labs to be drawn by:** Infusion Center Referring Physician
- No labs ordered at this time
 - CBC q _____ CMP q _____ CRP q _____
 - ESR q _____ LFTs q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

See Attached Medical Records

LAB AND TEST RESULTS (required)

- JC virus (JCV) antibody testing (submit results to start therapy and every 6 months to continue therapy)
 - o Continuation labs to be done by: Infusion Center Referring Physician

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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