



# TYSABRI

(natalizumab)

## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ M:  F:  Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Email: \_\_\_\_\_

Allergies: \_\_\_\_\_

## PRIMARY DIAGNOSIS

ICD-10 Code: \_\_\_\_\_

## DOCUMENTATION (PLEASE ATTACH)

### Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

- Patient enrolled in TOUCH program; prescriber is a TOUCH authorized provider
- Include anti-JCV antibodies test result within last 6 months. Patients who are anti-JCV antibody positive will require documentation from prescriber that risks/benefits have been discussed

**Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider**

## PRE-MEDICATION

<input type="checkbox"/> Acetaminophen 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Ceterizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> Loratadine 10mg PO	<input type="checkbox"/> Other: _____

## PRIMARY MEDICATION ORDER

### Dosage

300 mg IV

### Patient Weight:

lbs

kg

### Frequency

every 4 weeks for \_\_\_\_\_ treatments

### Last Dosage Of:

Avonex       Betaseron       Rebit

Date of Last Dose: \_\_\_\_\_

## NOTES

\_\_\_\_\_

## ORDERING PROVIDER

Provider Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_