Specialty Infusion Apothecary & Wellness Spa

INFUSION ORDERS-TYSABRI (NATALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

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

DIAGNOSIS AND ICD 10 CODE	
☐ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
☐ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other:_____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Pregnancy Test (if applicable)	☐ Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM
☐ Tried and Failed therapies	☐ 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	

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: ☐ X **6 months** ☐ X 1 year ☐ _____ doses		

PREMEDICATIONS
☐ Acetaminophen 650mg PO, 30-60 minutes prior to infusion
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to infusion
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion
☐ Other: _____

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

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: info@siainfusions.com or call (561) 955-7079
Fax completed form and all documentation to **(561) 617-5360**