(natalizumab)

TYSABRI infusion orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ __________ Multiple Sclerosis

☐ __________ Crohn's Disease

☐ __________ ____________________ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ ______________________________ *(other)*

☐ Length of Need ________________

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ ______________________________ *(other)*

TYSABRI ORDERS

DOSAGE

○ 300mg IV

FREQUENCY

○ every 4 weeks for __________ treatments

LAST DOSAGE OF:

○ Avonex ○ Betaseron ○ Rebif

PATIENT WEIGHT

________ lbs.

________ kg

○ Refills: ________________

Date of last dose: __________

Notes

____

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________

Address ____

____

NPI# ________________________

DEA# ________________________

FAX ORDERS: 702-780-4887