

TYSABRI (natalizumab)

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Phone: _____
 Status: New to therapy Continuing Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____
 Practice Address: _____ City: _____ State: _____ Zip: _____
 Practice Name: _____
 Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____
 Known Allergies: _____

Required Labs: STRATIFY JCV Antibody ELISA with reflex to inhibition assay, JCV with index

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: _____
- Patient's TOUCH authorization: _____
- Last MRI: _____

TYSABRI (natalizumab) ORDERS

<input type="checkbox"/> Dose: 300mg IV Frequency: <input type="checkbox"/> Once every 4 weeks x _____ doses Pre-Medication Orders: Tylenol 1000mg PO, and Antihistamine 25mg PO Date of last <input type="checkbox"/> Rebif <input type="checkbox"/> Betaseron <input type="checkbox"/> Avonex Dose: _____	Additional Orders/Comments: _____ _____ _____ _____
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ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

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| <ul style="list-style-type: none"> • Patient demographics • Patient medical insurance card, copied front and back • Patient pharmacy card, copied front and back (if they have one) | <ul style="list-style-type: none"> • Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results. • If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date. |
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PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____