

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- 1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Most Recent Labs
- 6. Anti-JCV antibody test 7. TOUCH enrollment

PRIMARY DIAGNOSIS

- G35.A Relapsing-remitting multiple sclerosis
- G35.B0 Primary progressive multiple sclerosis, unspecified
- G35.B1 Active primary progressive multiple sclerosis
- G35.B2 Non-active primary progressive multiple sclerosis
- G35.C0 Secondary Progressive multiple sclerosis, unspecified
- G35.C1 Active secondary progressive multiple sclerosis
- G35.C2 Non-active secondary progressive multiple sclerosis
- G35.D Multiple sclerosis, unspecified
- Other: _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: there are no recommended standard pre-meds for Tysabri
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Tysabri 300mg IV every 4 weeks Other _____
- FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
- Other Flush Orders: (Please send other line care orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
- Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

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PROVIDER SIGNATURE _____ DATE _____