LIFE SPECIALTY SOLUTIONS

TYSABRI
(natalizumab)

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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

✖ _____ _____

PROVIDER SIGNATURE DATE