

**INFUSION & MEDICAL CENTER**

1. \_\_\_\_\_  
**Patient Name** **DOB** **Patient Phone/Cell #**

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please complete/select appropriate diagnosis):**

Primary Diagnosis: \_\_\_\_\_ Relapsing Multiple Sclerosis ICD-10 Code: G35  
 Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes, labs, test supporting primary diagnosis
- Most Recent Labs including anti-JCV antibodies (within the last 6 months)
- Tysabri® TOUCH® Authorization Form
- Previous MS Drug Therapy History, including therapies trailed and or failed

<b>Patient Weight:</b> _____ lbs.
<b>Patient Height:</b> _____ in.

**TYSABRI® (natalizumab)**

J Code: J2323

**4. Drug Order:**

**Tysabri 300 mg IV over one (1) hour via a pump.**

Frequency: Administer every 28 days (4 weeks) \_\_\_\_\_ # Refills (Recommend 5 refills)

**Pre-Medication Orders:** Acetaminophen 650 mg PO  
 Administered 30 min prior to infusion \*Adjust to patient's needs

Other: \_\_\_\_\_

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
 Dispense as written Substitution permitted

Printed Physician's Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 803.999.1760</b>
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