



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

Tysabri ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies NKDA Allergies: _____

Height: _____ Weight: _____

Is the patient enrolled in the MS TOUCH Prescribing Program? Yes No

Indication:

G35.A Relapsing Remitting Multiple Sclerosis
 G50. ___ Moderate to Severe Active Crohn's
 Other

DRUG:

300mg IV every 4 weeks

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.
 Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
 Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.
 Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- JCV CBC CMP TB Hep B Other: _____

CAUTION:

Observe patient during all infusions. Post-infusion, for the first 12 infusions, observe patient for one hour after the infusion is complete