**Richmond**
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

**Prince George**
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

# Physician Order - Tysabri (natalizumab)

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Phone Number: |
| Patient Weight: _____ kg or _____ lb | Patient Height: _____ in |

| REFERRAL STATUS |
|---|
| ☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal |

| Location Preference (optional) |
|---|
| ☐ Richmond ☐ Prince George |

* * If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required * *

| DIAGNOSIS AND ICD-10 CODE | |
|---|---|
| ☐ Moderate to Severe Crohn's Disease | K50.90 |
| ☐ Mutliple Sclerosis | G35 |
| ☐ Other: _____ | ICD10 _____ |

| REQUIRED DOCUMENTATION (must include) | |
|---|---|
| ☐ This signed order form by the provider | ☐ Clinical/Progress Notes |
| ☐ Patient Demographics AND Insurance Information | ☐ Labs and Tests Supporting Primary Dx |
| ☐ JC Virus Antibody Test | |
| **Is the patient enrolled in the TOUCH Prescribing Program?** ☐ **Yes** | |
| ☐ Patient currently receiving same therapy at _____ Last dose: _____ | |
| List Tried & Failed Therapies, including duration of treatment | |
| 1) | 3) |
| 2) | 4) |

| MEDICATION ORDERS |
|---|
| Dosing ☐ Tysabri 300mg infuse IV over 1 hour every 4 weeks |
| Duration: ☐ x 6 months ☐ x 1 year ☐ x doses _____ |

| OPTIONAL PREMEDICATIONS and LAB ORDERS |
|---|
| ☐ Acetaminophen 650mg PO prior to infusion |
| ☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion |
| ☐ Methylprednisolone 100mg slow IVP prior to infusion |
| ☐ OPTIONAL: JC Virus DNA, PCR whole blood (LabCorp # 139370) every 6 months |
| ☐ Other PreMed or Lab Order with frequency: _____ |

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

| **PRESCRIBER INFORMATION** | | | |
|---|---|---|---|
| Prescriber Name: | NPI: | Contact: | |
| Phone: | Fax: | Email: | |
| Prescriber Signature: | | Date: | |

**Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com**
Fax completed form and ALL requried documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.