



# MEDICATION ORDERS

## TYSABRI (NATALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: <input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Relapsing-Remitting Multiple Sclerosis    ICD 10 Code: G35
<input type="checkbox"/> Secondary Progressive Multiple Sclerosis    ICD 10 Code: G35
<input type="checkbox"/> Primary Progressive Multiple Sclerosis    ICD 10 Code: G35
<input type="checkbox"/> Moderate to Severe Crohn's Disease    ICD 10 Code: K50.90
<input type="checkbox"/> Other: _____    ICD10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Pregnancy test (if applicable)	<input type="checkbox"/> Hepatitis B Test Results: HBsAG & HepB Core w/reflex IgG and IgM
	<input type="checkbox"/> Anti-JCV antibodies test result
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
If MS, current MS treatment and end of current therapy date:	
Is your patient currently enrolled in the TOUCH (FDA REMS) program <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Tysabri 300mg IV every 4 weeks
	<input type="checkbox"/> Tysabri 300mg IV every _____ weeks
Refills: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses	
<ul style="list-style-type: none"><li>• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.</li><li>• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.</li></ul>	

PREMEDICATIONS
<input checked="" type="checkbox"/> Acetaminophen 1000mg PO, 30-60 minutes prior to infusion
<input checked="" type="checkbox"/> Diphenhydramine 25mg IVP, 30-60 minutes prior to infusion
<input type="checkbox"/> Methylprednisolone 100mg IVPB, 30 minutes prior to infusion
<input type="checkbox"/> Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: **Montgomery (334) 273-7000 or Prattville (334) 351-1000**

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207