MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

TYSABRI (NATALIZUMAB)

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

REFERRAL STATUS
❑ New Referral ❑ Dose or Frequency Change ❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: ❑ Montgomery ❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Relapsing-Remitting Multiple Sclerosis	ICD 10 Code: G35
❑ Secondary Progressive Multiple Sclerosis	ICD 10 Code: G35
❑ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35
❑ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
❑ Other:_____	ICD10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
❑ This signed order form by the provider	❑ Clinical/Progress notes supporting primary diagnosis
❑ Patient demographics AND insurance information	❑ Labs and Tests supporting primary diagnosis
❑ Pregnancy test (if applicable)	❑ Hepatitis B Test Results: HBsAG & HepB Core w/reflex IgG and IgM
	❑ 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 ❑ Yes ❑ No	

MEDICATION ORDERS	
Dosing	❑ Tysabri 300mg IV every 4 weeks ❑ Tysabri 300mg IV every _____ weeks
Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses • 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. • 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.	

PREMEDICATIONS
✓ Acetaminophen 1000mg PO, 30-60 minutes prior to infusion
✓ Diphenhydramine 25mg IVP, 30-60 minutes prior to infusion
❑ Methylprednisolone 100mg IVPB, 30 minutes prior to infusion
❑ 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