TYSABRI® Infusion Referral Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Relapsing Multiple Sclerosis

_____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis 2. Most Recent Labs including anti-JCV antibodies (within the last 6 months) 3. Copy of the patient's Insurance Card 4. Medications List 5. Tysabri® TOUCH® Authorization Form 6. Previous MS Drug Therapy History, including therapies trailed and or failed

Physician Information

Prescribing Physician: _____ Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email: _____ Office Contact: _____

Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **TYSABRI® (natalizumab)**

Dose: _____ # Refills (Recommend 5 refills)

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

Frequency: Administer every 28 days (4 weeks)

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 below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date