



Tysabri® Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com Initial Order Reorder

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ Cell Alternate Phone #: _____ Cell

Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN# _____

Allergies: _____ NKDA

Diagnosis Information: Multiple Sclerosis G35 Multiple Sclerosis; Relapsing G35

Other Diagnosis/ICD10 code _____

Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? Yes No HTN? Yes No Cardiac History? Yes No Difficulty Breathing? Yes No

Requires Oxygen? Yes No Confusion /Disorientation? Yes No Neuro History? Yes No

JCV results: _____

Tysabri (natalizumab)®: J2323 **Provider Reviewed FDA/REMS recommendations**

Dose: 300mg IV over 1 hour every 28 days for _____ months

Is patient enrolled in the TOUCH program? Yes No

Pre-Medications: Patient to provide and take 30 minutes prior to infusion. Will receive 50ml of a 50ml bag of NS post infusion.

Benadryl 25 MG PO x1 Benadryl 50 mg PO x1

Acetaminophen 325 mg PO x1 Acetaminophen 650 mg PO x1

Other Pre-medication: _____ Follow IV Care Anaphylaxis Protocol

<p>Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5ml: Qty 3</p> <p>PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion</p>	<p>Supplies: (please strike through if not required)</p> <p>Administration Supplies (A4222) – 1 per infusion</p> <p>Catheter Care Supplies (A4221) – 1 per week</p> <p>Infusion Pump (E0781)</p> <p>Nursing services to administer medications</p> <p><i>Administer the anaphylaxis protocol for adverse reactions</i></p>
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Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St GA Zip: _____

Printed MD Name: _____ Contact Name: _____

Demographic information Patient Ins. Card H & P Office notes Failed therapies in documentation

Up to date medication list

9/23 TSP