



15200 Chenal Pkwy. Suite 300 Little Rock AR
 Phone: 501-451-6080 Fax:501-451-6081

TYSABRI (NATALIZUMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs (JCV), Tests** supporting primary diagnosis
- Patient's **TOUCH** authorization
- Last MRI

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis: Multiple Sclerosis (ICD-10: _____) Crohn's Disease (ICD-10: _____)

J Code: J0202

TYSABRI ORDERS

Tysabri Intravenous Dose: 300mg infused over 60 mins

Frequency: every 4 weeks (28 days) or other _____

Protocol Pre-medication Orders: Tylenol 650mg PO Antihistamine 25mg PO

****Date of last** Rebif Betaseron Avonex **Dose:** _____ **Date:** _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	