**AYSA**
THERAPEUTICS INFUSION

# TYSABRI (NATALIZUMAB) ORDER FORM

**P: 470.395.6076 | F: 470.745.0716**

## PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

**INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)**

## MEDICAL INFORMATION

J Code: J2323 Diagnosis: ☐ Multiple Sclerosis ICD-10 Code: _____

☐ Crohn's Disease ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ Patient's TOUCH authorization attached

☐ Last MRI attached

**Labs:** Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

**Lab Orders:** _____

## TYSABRI ORDERS

**Tysabri Intravenous Dose:** 300mg IV

**Frequency:** ☐ Once every 4 weeks x _____ doses

**Protocol Pre-Medication Orders:** Tylenol 1000mg PO, and Antihistamine 25mg PO

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

**Additional Instructions:**

## ADDITIONAL ORDERS/COMMENTS

## PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____