



AYSAs

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: _____

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