

TYSABRI (NATALIZUMAB) ORDER FORM

Patient Name:		DOB:	
Mobile Number	Patient Weight:	kg	Patient height: In
Allergies			
PROVIDER INFORMATION			
Provider Name		Provider NPI:	
Signature:		Date:	
Contact Name:	Phone:	Fax:	
Prerequisites to treatment — ensure the following information is complete and attached with referral:			
☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes			
DIAGNOSIS (Provider must specify)			
☐ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A ☐ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1 ☐ Clinically isolated syndrome (CIS), ICD 10: G36.9			
PRE-MEDICATION (Not typically indicated)			
☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Cetirizine 10 mg PO			
☐ Methylprednisolone (Soli-I-Medrol) 125mg IV ☐ Benadryl 25mg PO			
Other:		Dose:	Route:
Medication			
Medication	Dose	Route	Frequency
Tysabri	☐ 300 mg	IV	☐ Week 4 weeks
☐ 1 Year ☐ Or Refills:			
☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):			
LABS / SPECIAL INSTRUCTIONS			
Order valid for 1 year from date of signature unless otherwise specified Please fax your order to one of the following locations.			

One Care Infusion Pharmacy
 2025 Chicago Ave, STE A3
 Riverside, CA 92507
 Ph: 951-900-1120
 Fax: 951-900-1125

One Care Infusion Pharmacy
 907 W Coal Ave
 Gallup, NM 87301
 Ph: 505-726-4155
 Fax: 505-726-4304