



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
<input type="checkbox"/> G35 Multiple Sclerosis (MS) <input type="checkbox"/> Other ICD-10 Code (Please Specify Diagnosis): _____ Has the patient been tested for JCV virus? <input type="checkbox"/> Yes <input type="checkbox"/> No JCV Index: _____ Line Access: <input type="checkbox"/> PIV <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Midline Is Patient enrolled in TYSABRI® TOUCH® Program? <input type="checkbox"/> Yes <input type="checkbox"/> No Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
DRUG ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose/Strength	Directions	Refills
<input type="checkbox"/> Tysabri® (Natalizumab)	<input type="checkbox"/> 300mg/15ml Vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Infuse 300mg IV over 1 hour every 4 weeks <input type="checkbox"/> Other: _____	_____
Pre-Medication	Dose/Strength	Directions	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets by mouth prior to infusion	
<input type="checkbox"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take 1 tablet by mouth prior to infusion	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet by mouth prior to infusion <input type="checkbox"/> Administer ____ mg IV prior to infusion	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Administer ____ mg prior to infusion <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion	
<input type="checkbox"/> _____	_____	_____	
ANAPHYLACTIC REACTION (AR):			
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr <input type="checkbox"/> Other: _____			

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TYSABRI®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

SIGNATURE

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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