INTRAMED Plus
infusion services

TYSABRI®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnsosis):

Primary Diagnosis: _____ Relapsing Multiple Sclerosis ICD-10 Code: G35

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
- Most Recent Labs including anti-JCV antibodies (within the last 6 months)
- Tysabri® TOUCH® Authorization Form
- Previous MS Drug Therapy History, including therapies trailed and or failed

Patient
Weight: _____ lbs.
Height: _____ in.

TYSABRI® (natalizumab) J Code: J2323

4. Drug Order:

Tysabri 300 mg IV over one (1) hour via a pump.

Frequency: Administer every 28 days (4 weeks) Doses Authorized ❑ 12 or ❑ _____

Pre-Medication Orders: Acetaminophen 650 mg PO
Administered 30 min prior to infusion *Adjust to patient's needs

❑ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**