



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE, if applicable)

NEUROLOGY

- G35.A Relapsing Remitting Multiple Sclerosis
- G35.B0 Primary Progressive Multiple Sclerosis, unspecified
- G35.B1 Active Primary Progressive Multiple Sclerosis
- G35.B2 Non-active Primary Progressive Multiple Sclerosis, unspecified
- G35.C0 Secondary Progressive Multiple Sclerosis, unspecified
- G35.C1 Active Secondary Progressive Multiple Sclerosis
- G35.C2 Non-active Secondary Progressive Multiple Sclerosis
- G35.D Multiple Sclerosis, unspecified

GASTROENTEROLOGY

- K50.0 _____ Crohn's Disease, Small Intestine
- K50.1 _____ Crohn's Disease, Large Intestine
- K50.8 _____ Crohn's Disease, Small & Large Intestine
- K50.9 _____ Crohn's Disease, Unspecified

REQUIRED: Demographics & Most Recent: H&P, clinical notes, lab results & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

LAB RESULTS: Include anti-JCV antibodies test results within the last 6 months (patients who are anti-JCV antibody positive will require documentation from prescriber that risks/benefits have been discussed).

PRESCRIPTION

Pre-Medications

- Acetaminophen: 650 mg PO
- Cetirizine 10 mg PO
- Dexamethasone: _____ mg IV
- Diphenhydramine: 25 mg PO
- Diphenhydramine: 25 mg IV
- Other: _____
- Acetaminophen: _____ mg PO
- Famotidine: _____ mg IV
- Loratadine 10 mg PO
- Methylprednisolone: _____ mg IV
- Ondansetron: 4 mg IV

Lab Orders

- CBC w/diff: every _____ weeks month
- CMP: every _____ weeks month
- Other: _____

Tysabri (natalizumab)

Dose and Frequency

- IV: infuse 300 mg every 4 weeks x 1 year
- IV: Infuse 300 mg every ___ weeks x 1 year

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**** Post-treatment Observation: Patient will be observed for 1 hour following the first 12 infusions. ****

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: _____

**** Patient must be enrolled in the Touch Program by the ordering provider for the patient to receive Tysabri (natalizumab). ****

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____