

Tysabri Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: New Referral Dose or Frequency Change Order Renewal
 Location: Jackson Knoxville Morristown Kingsport

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (check one) M F
 Home Phone: _____ Mobile Phone: _____
 Email: _____ Last 4 of SS#: _____
 Allergies: _____ Height: _____ Weight: _____
 ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____
 TB Test (circle one): Skin Quantiferon Chest X-ray Result: _____ Date: _____

THERAPY ORDERS

Patient has been enrolled in TOUCH Program
 Administer Tysabri (Natalizumab) 300 mg IV every four weeks **OR**
 (specify): _____
 Nursing per Heartland Nursing Procedures (include reaction management)

PRE-MEDICATION No routine pre-medications required

Tylenol (acetaminophen) _____mg PO Zyrtec (cetirizine) 10mg PO
 Solu-Medrol (methylprednisolone) IV 40 mg, 125 mg, other _____mg Claritin (loratadine) 10mg PO
 Benadryl (diphenhydramine) _____mg PO IV
 Other: _____

LABORATORY ORDERS

<input type="checkbox"/> CBC w/ DIFF	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Quantiferon TB (annually)		Due: _____
<input type="checkbox"/> Other: _____		

PRESCRIBER'S INFORMATION

Prescriber Name: _____
 License #: _____ NPI: _____ DEA: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Office Contact: _____
 Office Phone: _____ Office Fax: _____
 Prescriber's Signature: _____

