TYSABRI (NATALIZUMAB) INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:	
Office Contact:			Email:	
Address:		City:	State:	ZIP:
NPI #:	DEA#:		Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Tysabri (natalizumab)	□ 300mg IV every 4 weeks □ 300mg IV every _____ weeks □ Other: _____	□ x 1 year □ _____

Pre-Medication Orders:

□ Tylenol 1000mg PO
□ Cetirizine 10mg PO
□Diphenhydramine 25mg PO
□ Loratadine 10mg PO

Additional Pre-Medication Orders:

□ Solu-Medrol _____ mg IVP
□ Solu-Cortef _____ mg IVP
□ Other: _____

Other orders: _____

Lab orders: _____ Lab frequency: _____

Required labs to be drawn by: □ LIVbetter □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR TYSABRI (NATALIZUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- □ Include signed and completed order (MD/prescriber to complete page 1)
- □ Prescriber is a TOUCH authorized provider
- □ Patient enrolled in TOUCH Program
- □ Include patient demographic information and insurance information
- □ Include patient's medication list
- □ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to therapy
  - □*MS* - Expanded Disability Status Scale (EDSS) score: _____
  - □*Crohn's Disease* - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Remicade, Stelara) and/or an immunomodulator?
    - □ Yes □ No If yes, which drug(s)? _____
- □ Include labs and/or test results to support diagnosis
  - □ MRI (*MS*)
  - □ JCV Antibody
  - □ ESR/CRP (*Crohn's*)
- □ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching biologic therapies, please perform a wash-out period of _____ weeks prior to starting natalizumab.
- □ Other medical necessity: _____

REQUIRED PRE-SCREENING

□JCV Antibody - attach results

□Positive □ Negative