

TOUCH® Prescribing Program (REMS) — required before any dose. ☐ Prescriber is TOUCH-certified for this indication ☐ Patient enrolled and enrollment form signed ☐ Reauthorization current (every 6 months)

MS TOUCH and CD TOUCH are separate registrations — the prescriber must be certified for the indication being ordered.

PATIENT INFORMATION

PATIENT NAME		DATE OF BIRTH	PHONE
WEIGHT		ALLERGIES	PATIENT STATUS ☐ New ☐ Continuing

REFERRING PRESCRIBER & INSURANCE

PRESCRIBER NAME	NPI #	PHONE	FAX
PRIMARY INSURANCE	POLICY #	GROUP #	NEXT TREATMENT DATE

DIAGNOSIS ICD-10 required — Tysabri is approved for two separate indications

MULTIPLE SCLEROSIS ☐ G35 Multiple sclerosis ☐ G37.9 Demyelinating disease of CNS, unspecified (clinically isolated syndrome) <i>Relapsing forms only — relapsing-remitting or active secondary progressive.</i> EDSS score: _____	CROHN'S DISEASE ☐ K50.90 Crohn's disease, unspecified, without complications ☐ K50.00 Crohn's disease of small intestine, without complications ☐ K50.10 Crohn's disease of large intestine, without complications ☐ K50.80 Crohn's of both small and large intestine, without complications <i>For disease with complications, use the matching K50.x1x code.</i>
OTHER ICD-10	PRIMARY DIAGNOSIS DESCRIPTION

TYSABRI ORDER

☐ 300 mg IV every 4 weeks — standard labeled dosing for both indications	
☐ 300 mg IV every _____ weeks — extended interval dosing. <i>Not FDA-approved labeling; order at prescriber discretion.</i>	
☐ Other: _____	
☐ Dispense the natalizumab product the patient's plan covers (Tysabri or Tyruko biosimilar) — LIVbetter to select	
Administration	Dilute in 100 mL 0.9% sodium chloride and infuse over 1 hour. Do not give as an IV push or bolus.
Observation	Observe during the infusion and for 1 hour after each of the first 12 infusions. From the 13th infusion, if no hypersensitivity reaction has occurred, post-infusion observation is at clinical judgment.
Crohn's only	Discontinue if there is no therapeutic benefit by 12 weeks of induction. Do not combine with immunosuppressants or TNF blockers; aminosalicylates may continue. Begin tapering chronic oral steroids once benefit occurs; discontinue natalizumab if steroids cannot be tapered off within 6 months.

PRE-MEDICATION optional — no routine pre-medication is required by the label

Antipyretic	☐ Acetaminophen (Tylenol) ☐ 650 mg ☐ 1,000 mg PO
Antihistamine	☐ Diphenhydramine 25 mg ☐ PO ☐ IV ☐ Cetirizine 10 mg ☐ PO ☐ IVP ☐ Loratadine 10 mg PO
Additional	☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

REQUIRED BEFORE THE FIRST DOSE insurance will not approve without these — please attach results

☐ Anti-JC virus antibody — result: ☐ Negative ☐ Positive ☐ Attached <i>A positive result at any time counts as positive. Negative patients remain at risk and should be retested periodically. Do not test within 2 weeks of plasma exchange or 6 months of IVIg.</i>	☐ MRI — multiple sclerosis ☐ ESR / CRP — Crohn's disease ☐ Liver function tests — ALT, AST, alkaline phosphatase, bilirubin ☐ No active infection — confirm before every infusion
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LABS, OTHER ORDERS & DOCUMENTATION

Lab orders	Labs: _____ Frequency: _____ Drawn by: ☐ LIVbetter ☐ Referring provider
Other orders	_____
Prior therapy	Last biologic: _____ Last dose received: _____ Washout before natalizumab: _____ weeks Crohn's — failed or intolerant to a TNF blocker or immunomodulator? ☐ Yes ☐ No Which: _____
Attach	☐ Signed order ☐ Demographics + insurance ☐ Medication list ☐ Clinical notes incl. tried / failed therapy ☐ Other: _____

PRESCRIBER SIGNATURE required — we cannot schedule without it

PRESCRIBER SIGNATURE X	DATE	DISPENSE AS WRITTEN ☐ Yes
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