MRN:_____
DOB:_____

Standard Tysabri Plan of Treatment

NOTE: Patient ***may be ineligible*** to receive Tysabri if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Name: _____ Height_____ Weight:

Allergies:_____

Primary Diagnosis: **ICD-10 G35 Relapsing Multiple Sclerosis**

This section must be completed by the referring physician.

Patient has been on the following medication(s) for treatment of MS (Must have failed 2 or more MS medications):
_____.

These medications will be discontinued as of_____.

Patient may receive Tysabri after wash-out period of_____ weeks or_____months.

If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Premedicate 30 minutes prior to infusion with 650 mg Acetaminophen PO and one of the following *oral* antihistamines:

☐ Diphenhydramine 50mg ☐ Fexofenadine ☐ Fexofenadine ☐ Cetirizine10mg ☐ Loratadine 10 mg

OR Premedicate with other _____

Drug:

Tysabri 300mg in 100ml NS IV over 1 hour Every 4 weeks, Monitor pt. for 1 hour post infusion

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physician's Signature:_____/_____Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name:_____

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.