Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Tysabri® (natalizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: ☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	G35 - Relapsing Multiple Sclerosis	☐	K50.9_____ - Crohn's Disease
☐	K50.8_____ - Crohn's Disease (small & large intestine)	☐	K50.0_____ - Crohn's Disease (small intestine)
☐	K50.1_____ - Crohn's Disease (large intestine)	☐	_____ - Other:_____

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Anti-JCV antibodies as required by payer or REMS program

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive natalizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of therapy.

IV	Diphenhydramine	☐ 25mg	☐ 50mg			
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:		
	Famotidine	☐ 20mg	☐ 40 mg			
	Other:	☐				

PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg	
	Famotidine	☐ 20mg	☐ 40mg			
	Diphenhydramine	☐ 25mg	☐ 50mg			
	Fexofenadine	☐ 60mg	☐ 180mg			
	Cetirizine	☐ 10mg				
	Loratadine	☐ 10mg				
	Other:	☐				

MEDICATION:

☑ Tysabri® (natalizumab) 300 mg in 100 ml NS IV to infuse over at least 1- hour.

Follow first 12 infusions with a one hour post infusion observation.

FREQUENCY:

☐ Dosing every 4 weeks, no less than every 28 days.
☐ Other: _____

LAB ORDERS:

☐ Draw JCV antibody test every 6 months
☐ Draw JCV antibody test every _____

SPECIAL/OTHER LAB ORDERS:

☐ _____
_____

Prescriber to monitor patient for symptoms of PML as clinically appropriate.

***Prior to each infusion: ensure that the patient has a current Notice of Patient Authorization on file to receive Tysabri® (natalizumab) for their diagnosis and complete/submit Pre-infusion Patient Checklist within 24 hours to Biogen Idec**

☑ Refills x 12 months unless noted otherwise here:

CARE ORDERS:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- ☐ **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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com