(natalizumab)

TYSABRI infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis

☐ _____ Crohn's Disease

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

TYSABRI ORDERS

DOSAGE

◉ 300mg IV

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

○ every 4 weeks for _____ treatments

LAST DOSAGE OF:

○ Avonex ○ Betaseron ○ Rebif Date of last dose: _____

NOTES

_____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____

Please return by fax to: (806) 503-2200 or email to: referrals@icareama.com.