HONORHEALTH®

NATALIZUMAB
(Tysabri)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status ☐ New Order ☐ Renewal ☐ Dose or Frequency Change

Diagnosis
- ☐ Crohn's Disease
- ☐ Multiple Sclerosis, relapsing
- ☐ Other:

Diagnosis Code: _____

Required Information (Please include labs attached)

Allergies:

Negative QuantiFERON TB or T-spot or chest x-ray	Date:	Weight: _____
Diagnostic Hepatitis B Panel	Date:	
Coccidioides Screen/Panel	Date:	Height: _____
CBC, CMP (please include lab result documents)	Date:	

Labs ☐ Hepatic Function panel every: ☐ Other:

Pre-Medications
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg ☐ IV ☐ PO
- ☐ Acetaminophen ☐ 325mg ☐ 650mg ☐ PO
- ☐ Other:

- ☐ Tysabri 300mg IV every 4 weeks
- ☐ Other:

- ☐ Concomitant use with corticosteroids (recommend to taper off corticosteroids within 6 months of Tysabri initiation)

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation
- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: