REVITALIZE
INFUSION CENTER

Tysabri®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Relapsing Multiple Sclerosis ICD-10 Code: G35

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies
- Required Information:
  - Recent labs including anti- JCV antibody
  - Tysabri TOUCH authorization form

Height: _____

Weight: _____

Tysabri (natalizumab) Orders:

Administer 300 mg intravenously every 4 weeks for 12 months

☐ Other:_____

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg IV

☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO

☐ Other: _____

Lab Orders:

☐ CBC with Diff every 3 months ☐ CMP every 3 months

☐ JCV titer every 6 months ☐ Vitamin D every 12 months

☐ Serum Pregnancy (if applicable)

☐ Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus