TYSABRI INFUSION ORDER
(Natalizumab)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Lab Orders: _____

PRE-MEDICATIONS

Benadryl	O PO	O IV	O 25mg	O 50mg	O PreMed	O PRN
Acetaminophen	O PO			O 650mg	O PreMed	O PRN

TYSABRI (NATALIZUMAB) IV DOSAGE

300 mg IV every 4 weeks
Other: _____ Duration: _____
*** MUST BE ENROLLED AND AUTHORIZED IN THE TYSABRI TOUCH PROGRAM**

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994