

NATALIZUMAB

(Including Tysabri and biosimilar Tyruko)

FLEXCARE
INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Anti-JCV antibody test
- REMS program enrollment

PRIMARY DIAGNOSIS

- | | |
|---|---|
| <input type="checkbox"/> G35.A Relapsing-remitting multiple sclerosis | <input type="checkbox"/> G35.C1 Active secondary progressive multiple sclerosis |
| <input type="checkbox"/> G35.B0 Primary progressive multiple sclerosis, unspecified | <input type="checkbox"/> G35.C2 Non-active secondary progressive multiple sclerosis |
| <input type="checkbox"/> G35.B1 Active primary progressive multiple sclerosis | <input type="checkbox"/> G35.D Multiple sclerosis, unspecified |
| <input type="checkbox"/> G35.B2 Non-active primary progressive multiple sclerosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> G35.C0 Secondary progressive multiple sclerosis, unspecified | |

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Natalizumab

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- ☐ Natalizumab 300mg IV every 4 weeks
- ☐ Other: _____

First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

REVISED 11/25