Phone : 844-800-5377 Fax : 214-782-9155

TYSABRI (natalizumab) Rx ENROLLMENT FORM

PATIENT INFORMATION

Patient Name:		Date of Birth:	Gender:
Home Phone:	Cell Phone:	Email:	
Address:	City:	State:	Zip:
Emergency Contact:		Emergency Phone:	

CLINICAL INFORMATION

Diagnosis:
- ☐ G35.A Relapsing-remitting multiple sclerosis
- ☐ G35.B0 Primary progressive multiple sclerosis, unspecified
- ☐ G35.B1 Active primary progressive multiple sclerosis
- ☐ G35.B2 Non-active primary progressive multiple sclerosis
- ☐ G35.C0 Secondary progressive multiple sclerosis
- ☐ G35.C1 Active secondary progressive multiple sclerosis
- ☐ G35.C2 Non-active secondary progressive multiple sclerosis
- ☐ G35.D Multiple sclerosis, unspecified
- ☐ Other: ______________________

Patient Weight: __________ ☐ kg ☐ lbs
Patient Height: __________ ☐ cm ☐ in
Allergies: ______________________
Has the patient been tested for JCV Virus? ☐ Yes ☐ No JCV Index: ______
Is patient enrolled in TYSABRI® TOUCH® Program? ☐ Yes ☐ No

PRESCRIBER INFORMATION

Prescriber Name: ______________________
DEA #: __________ NPI #: __________
Address: ______________________
City: __________ State: ______ Zip: ______
Phone: __________ Fax: __________
Contact Person: ______________________

REQUIRED DOCUMENTATION

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

PRESCRIPTION INFORMATION

Prescription type: ☐ New start ☐ Restart ☐ Continued Therapy Total Doses Received: ________ Date of Last Dose: ________

Medication	Dose	Directions	Refill
☐ **TYSABRI®** **(Natalizumab)**	☐ 300mg/15mL vial ☐ Other: ________	☐ Infuse 300mg IV over 1 hour every 4 weeks ☐ Other: ________	________

ORDERS

IV Access	☐ PIV ☐ PORT ☐ PICC ☐ Midline	
Pre-Medications Please strikethrough if not required	☐ **Acetaminophen** ☐ 500mg	**Take 1-2 tablets PO 30 minutes prior to infusion or post-infusion as directed**
	☐ **Diphenhydramine** ☐ 25mg IV/PO ☐ 50mg IV/PO	☐ **Take 1 tablet PO prior to infusion or as as directed OR** ☐ **Inject contents of 1 vial IV prior to infusion or as directed**
	☐ **Methylprednisolone (Solu-Medrol)** ☐ 40mg ☐ 100mg ☐ 125mg	☐ **Inject contents of 1 vial IV prior to infusion or as directed** ☐ **Other: Inject 100mg IV 30 minutes prior to infusion**
	☐ Other: ________	________
Anaphylaxis Protocol	☐ Epi-pen® Auto-injector 0.3mg (1:1000) **Inject IM or SubQ to patients who weigh ≥ 66lbs (≥ 30kg); may repeat in 3-5 mins x 1 if necessary** ☐ Epi-pen Jr® Auto-injector 0.15mg (1:2000) **Inject IM or SubQ to patients who weigh 33-66lbs (15-30kg) ; may repeat in 3-5 mins x 1 if necessary** ☐ Diphenhydramine 50mg (1mL) **Give 50mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary** ☐ Methylprednisolone 40mg IVP	
Additional Orders		

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible		☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute	
Prescriber Signature ________	**Date** ________	**Prescriber Signature** ________	**Date** ________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ________ **NY & Iowa** providers, please submit electronic prescription.

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