

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 Most Recent Labs

History & Physical Anti-JCV antibody test

Patient Demographics REMS program enrollment

Current Medication List

PRESCRIPTION INFORMATION

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

| Medication | Dose | Directions | Refill |
|--|---|---|--------|
| <input type="checkbox"/> TYSABRI® (Natalizumab) | <input type="checkbox"/> 300mg/15mL vial <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Infuse 300mg IV over 1 hour every 4 weeks <input type="checkbox"/> Other: _____ | _____ |

ORDERS

IV Access PIV PORT PICC Midline

Pre-Medications
Please strikethrough if not required

| | |
|---|--|
| <input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg | Take 1-2 tablets PO 30 minutes prior to infusion or post-infusion as directed |
| <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO | <input type="checkbox"/> Take 1 tablet PO prior to infusion or as as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed |
| <input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg | <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion |
| <input type="checkbox"/> 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.

| | |
|--|---|
| <input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible | <input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute |
| Prescriber Signature | Prescriber Signature |
| Date | 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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