Phone: 616-954-0600 Fax: 616-954-1675

Tysabri IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

In the last 6 months, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Labs to be collected: ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐Hepatic Panel ☐ JCV with index ☐ Other:_____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Every _____months ☐ Other:_____

Patient must be enrolled in Tysabri TOUCH Program

Tysabri (natalizumab) 300 mg IV

Frequency: ☐ **Every 4 weeks** ☐ **q _____ weeks**

Rx Expiration Date: _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____