

Tysabri® (natalizumab) Referral Form



www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:
		Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per BioHealth protocols.

TYSABRI THERAPY ADMINISTRATION

300 mg IV every 4 weeks

LABORATORY ORDERS

CBC At each dose Every _____
CMP At each dose Every _____
CRP At each dose Every _____
OTHER

REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card/Information
- Progress Notes Supporting DX
- Current Medication List and H&P
- JCV Antibody
- Current MS Drug _____

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 10000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

Type of MS: Relapsing Remitting Primary Progressive

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) Provider Signature Date

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
8684 SUNSET DRIVE MIAMI FL 33143