Natalizumab (Tysabri)
Patient Referral Form

Infusion Specialist
c:
e:

PATIENT INFORMATION

Date: Patient Name: DOB: Last 4 SSN:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐M ☐F Weight lbs/kg: ICD-10 code: ICD-10 Description:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy If yes, did patient have reaction with 1st dose? ☐ Y ☐ N

☐ Next Due Date (if applicable):_____

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

ATTACH DOCUMENTS TO FAX

☑ Copy of insurance card(s) ☑ Labs ☑ Immunization results, include HBV and TB
☑ Patient demographics ☑ H&P (clinical) Other: _____

NURSING

☑ Provide nursing care per Axiva Standard Nursing Procedures, including reaction management & post-infusion observation
☑ Verify patient is enrolled and authorized in TOUCH program. Complete pre-infusion checklist at www.touchprogram.com; notify provider of any contraindications to infusion.

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: _____
Dose: _____ Route: _____
Frequency:

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ STRATIFY JCV Antibody ELISA with reflex to inhibition assay, JCV with index
☐ Other: _____

THERAPY ADMINISTRATION

☑ **Natalizumab** (Tysabri) in 100ml 0.9% sodium chloride, intravenous infusion
☐ Induction:
- Dose: 300mg
- Frequency: ☐ every 4 weeks / ☐ other: _____
- Infuse over 60 minutes

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ Other: _____
☑ Flush with 0.9% sodium chloride at the completion of infusion
☐ Patient is required to stay for 1-hour observation post infusion
☐ Patient is NOT required to stay for observation time

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name: NPI: DEA: License:

Address: City: ST: Zip:

Phone: Fax: Office Contact:

_____ _____ ♦ _____ _____
Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date

FAX completed form to Axiva 844.440.0101 **Patient Navigator 844.44-AXIVA (844.442.9482)**