

March 2024

# LOWCOUNTRY Rheumatology

A Member of Articularis Healthcare Group, Inc.

Please fax completed form, insurance card, and clinical documentation to:  
**FAX: (843) 793-6181**

## Tysabri ORDER

New Start  Maintenance: Last Dose Given \_\_\_\_\_

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies  NKDA  Allergies: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Is the patient enrolled in the MS TOUCH Prescribing Program?  Yes  No

**Indication:**

G35. \_\_\_ Relapsing Multiple Sclerosis

G50. \_\_\_ Moderate to Severe Active Crohn's

Other \_\_\_\_\_

**DRUG:**

300mg every 4 weeks

**PREMEDICATION ORDERS:** *not required by PI*

Acetaminophen po:  1000mg  500mg 30 min prior to infusion.

Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30 min prior to infusion.

Solu-Medrol:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30 min prior to infusion.

Other \_\_\_\_\_

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

**Referrals will not be processed until we receive ALL the following:**

- Face Sheet / Patient Demographics
  - Insurance card(s) – copy of front & back
  - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- JCV  CBC  CMP  TB  Hep B Other: \_\_\_\_\_