

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 Lipids TB Hep B Other: _____