

NATALIZUMAB (AND BIOSIMILAR) ORDER FORM

- Tyruko (natalizumab-sztn) Tysabri (natalizumab)
 Dispense As Written (DAW) Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Comments: _____
 New Start Therapy | Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

- Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
 Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
 Acute disseminated demyelination, unspecified, ICD 10: G36.9
 Moderately to severely active Crohn's disease, ICD 10: K50.0
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Natalizumab	300 mg	IV	<input type="checkbox"/> Every 28 days <input type="checkbox"/> Other: _____

OTHER NOTES

Order valid for 1 year from date of signature unless otherwise specified here: _____