

# Tysabri Order Form

*Pre-filled order form for Tysabri (natalizumab) — Highly effective MS and Crohn’s therapy*

**REFERRING PROVIDER**

<b>PROVIDER NAME</b>	<b>NPI</b>	<b>DEA (IF CONTROLLED)</b>	<b>SPECIALTY</b>
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<b>PRACTICE / CLINIC NAME</b>	<b>OFFICE PHONE</b>	<b>OFFICE FAX</b>
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<b>OFFICE CONTACT NAME</b>	<b>CONTACT PHONE</b>	<b>CONTACT EMAIL</b>
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**PATIENT INFORMATION**

<b>PATIENT LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>
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<b>DATE OF BIRTH</b>	<b>SEX</b>	<b>PATIENT PHONE</b>	<b>BEST TIME TO CONTACT</b>
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<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
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**INSURANCE**

<b>PRIMARY INSURANCE</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
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<b>SECONDARY INSURANCE (IF ANY)</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
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**DIAGNOSIS & CLINICAL JUSTIFICATION**

<b>PRIMARY DIAGNOSIS</b>	<b>ICD-10 CODE</b>
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<b>SECONDARY DIAGNOSIS (IF APPLICABLE)</b>	<b>ICD-10 CODE</b>
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**Common indications for this medication:** *Relapsing forms of multiple sclerosis, Moderate to severe Crohn’s disease*

**BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY**

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**PRIOR THERAPIES TRIED AND OUTCOME**

**TYSABRI REFERENCE**

**Generic name:** natalizumab  
**Specialty:** Neurology & Gastroenterology  
**Typical infusion time:** About 1 hour  
**Typical schedule:** Every 4 weeks  
**Biosimilars / brands:** Tyruko

**MEDICATION ORDER**

MEDICATION (DEFAULT: TYSABRI)	GENERIC / ALT (NATALIZUMAB)	STRENGTH / FORMULATION
<b>DOSE</b>	<b>FREQUENCY (TYPICAL: EVERY 4 WEEKS)</b>	<b>DURATION (TYPICAL: ABOUT 1 HOUR)</b>
<b>ROUTE</b>	<b>PRE-MEDICATIONS (IF ANY)</b>	<b>SPECIAL INSTRUCTIONS</b>
<b>ANTICIPATED START DATE</b>	<b># OF DOSES AUTHORIZED</b>	<b>SUBSTITUTION ALLOWED (Y/N)</b>
		<b>BIOSIMILAR ACCEPTABLE (Y/N)</b>

**REQUIRED LABS & MONITORING**

Check all labs the prescriber requires Arbor to verify before each infusion:

- CBC w/ differential
- Hepatitis B/C panel
- Iron studies (ferritin, TSAT)
- CMP
- TB screen (T-SPOT or QFT)
- Vitamin levels (B12, D, folate)
- Liver function panel
- Pregnancy test (urine)
- Other (specify below)

**OTHER LABS / MONITORING REQUIREMENTS**

**PRESCRIBER SIGNATURE**

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

**PRESCRIBER SIGNATURE** **PRINTED NAME** **DATE**



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*Form code: ARB-ORDER-TYSABRI · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com*