



Birmingham, AL
F: 205-271-9971

Huntsville, AL
F: 256-417-6408

Knoxville, TN
F: 865-934-0249

Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Relapsing Multiple Sclerosis
 _____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis 2. Most Recent Labs including anti-JCV antibodies (within the last 6 months) 3. Copy of the patient's Insurance Card 4. Medications List 5. Tysabri® TOUCH® Authorization Form 6. Previous MS Drug Therapy History, including therapies trailed and or failed

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: TYSABRI® (natalizumab)

Dose: _____ # Refills (Recommend 5 refills)

Administer Tysabri 300 mg IV over one (1) hour via a pump.

Frequency: Administer every 28 days (4 weeks)

Pre-Medication Orders:

Acetaminophen 650 mg PO, Administered 30 min prior to infusion *Adjust to patient's needs

Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date