

**TYSABRI® Infusion Referral Form****Fax Referral To:  
877-438-9380****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

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.