MS Infusions

TYSABRI (NATALIZUMAB) INFUSION ORDERS

PATIENT INFORMATION ☐ **DEMOGRAPHICS ATTACHED**

INSURANCE INFORMATION: PLEASE ATTACH COPY OF INSURANCE CARD (FRONT AND BACK)

NAME: **DOB:** **PHONE:**

DIAGNOSIS J CODE: J2323	☐ MULTIPLE SCLEROSIS (ICD-10 CODE: _____
ALLERGIES	PATIENT WEIGHT LBS
☐	CLINICAL/PROGRESS NOTES, LABS, TESTS SUPPORTING PRIMARY DIAGNOSIS ATTACHED
☐	CURRENT HISTORY & PHYSICAL WITH COMPLETE MEDICATION LIST ATTACHED
☐	PATIENT'S **TOUCH** AUTHORIZATION ATTACHED
☐	LAST MRI ATTACHED
JCV Status	STATUS OF JCV ANTIBODY ☐ POSITIVE ☐ NEGATIVE DATE:_____

TYSABRI ORDERS

TYSABRI	☐ 300 MG IV ONCE, THEN EVERY 28 DAYS X _____ DOSES (STANDARD INTERVAL) ☐ 300 MG IV ONCE, THEN EVERY 5-8 WEEKS X _____ DOSES (EXTENDED INTERVAL)
PRE MEDICATIONS	☐ TYLENOL 1000 MG PO ☐ CLARITIN 10 MG PO ☐ TORADOL 30 MG IV ☐ BENADRYL 25 MG PO
DATE OF LAST	MS Treatment: Type Dose Date: N/A
ADDITIONAL ORDERS & INSTRUCTIONS	

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing MIND and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescribing insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

CHECK AN INFUSION LOCATION: Phone 248.553.0010 ext. 431 FAX 248.553.6201

☐ **28595 Orchard Lake Road, Suite 200**
Farmington Hills, MI 48334

☐ **25150 Ford Road, Suite 100**
Dearborn Heights, MI 48127

☐ **27301 Dequindre, Suite 103**
Madison Heights, MI 48071