



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
- 25100 Kelly Road
Roseville, MI 48066