

**Fax form to:**

Billings - 719.300.4068      Colorado Springs - 719.300.4068  
 Great Falls - 406.384.7002      Grand Junction - 970.822.7700  
 Boise - 208-488-4998

**INFUSION ORDERS TYSABRI (Natalizumab)**

**Patient's Information**

Date of Referral

First Name      Last Name      M.I.  
           

Date of Birth

Address

City      State      ZIP Code  
           

Phone

WT (kg)      HT (in)  
     

Diagnosis

Allergies

**\*Please fax all recent labs including TB date/results, Hepatitis B results and JCV.**

\*ICD 10 CODE

**\* Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

**REMICADE DOSING**

- Remicade dose of 3mg/kg
- Remicade dose of 5mg/kg
- Remicade dose of 10mg/kg
- Remicade dose of 5mg/kg

Refills:

**Frequency**

- Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter

Specific dosing frequency of

Premedications

Prescribing Provider

Address

City      State      ZIP Code  
           

**Provider Signature**       Date

Provider Phone      Provider Fax