

Fax form to:

Billings - 406.206.0105 Colorado Springs - 719.623.0085
 Great Falls - 406.794.0555 Grand Junction - 970.404.8100
 Boise - 208.545.3214

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.**

TYSABRI DOSING

300mg IV Infusion every 4 weeks

Tysabri 300mg IV every weeks

Additional Info

Premedications

Prescribing Provider

Address

City State ZIP Code

Provider Signature Date

Provider Phone Provider Fax