TYSABRI (NATALIZUMAB) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

TYSABRI MEDICATION ORDERS

Dosing: ☐ 300 mg Frequency: ☐ IV every 4 weeks.

INDICATION/DIAGNOSIS

- ☐ K50.90 Crohn's disease unspecified, without complications
- ☐ G35 Relapsing MS
- ☐ Multiple Sclerosis
- ☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along w/ any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ JCV Antibody ☐ CMP (w/in past 3 months) ☐ CBC with differential (w/in past 3 months)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY