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**TYSABRI (NATALIZUMAB)
 INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- Patient's **TOUCH** authorization
- Last MRI

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis: Multiple Sclerosis (ICD-10: _____) Crohn's Disease (ICD-10: _____)

J Code: J0202

TYSABRI ORDERS

Tysabri Intravenous Dose: 300mg infused over 60 mins

Frequency: Once a day, every 4 weeks X _____ doses

Protocol Pre-medication Orders: Tylenol 1000mg PO Antihistamine 25mg PO

****Date of last** Rebif Betaseron Avonex **Dose:** _____ **Date:** _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	