TYSABRI® Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐M ☐F

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

Patient's first dose? ☐Yes ☐No (If no, Treatment start date: _____ Date of last dose: _____)

Prior infusion reactions: _____

Anti-JCV antibody: Date: _____ ☐Negative ☐Positive If positive, antibody titer: _____

Prior immunosuppressant use: ☐Yes ☐No If yes, please list: _____

Prescription Information

Dosing Regimen	Quantity
☐ Infuse TYSABRI® 300mg in 100mL NaCl 0.9% over 60 minutes every four (4) weeks.	_____ doses (infusions)

Nursing and Supplies: OptiMed to provide additional supply items and nursing care to prepare and administer product as per package instructions.

Premedication(s):

☐Acetaminophen 325-650mg PO 15-30 minutes prior to infusion ☐Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion

☐Other premedication(s): _____

PRN Medication(s):

☐Acetaminophen 325-650mg PO Q4 hours PRN ☐Diphenhydramine 50mg IV x1 dose PRN ☐Methylprednisolone 125mg IV x1 dose PRN

☐Other PRN medication(s): _____

Post-Infusion: Patient to receive post-infusion monitoring and hydration with 500mL NaCl 0.9% infused over 60 minutes following each TYSABRI® infusion.

Lab orders: List any outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the patient's medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. (Lab orders are subject to availability.)

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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CLEAR FORM