OKLAHOMA INFUSION SERVICES

Tysabri Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ G35 Multiple Sclerosis
Type: ☐ Relapsing-Remitting ☐ Primary-Progressive ☐ Secondary-Progressive ☐ Progressive-Relapsing
☐ K50.00 Crohn's Disease of Small Intestine without Complications
☐ K50.90 Crohn's Disease, Unspecified, without Complications
☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg
☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____
☐ Hep B Test: Date: _____ Results: _____
☐ Does patient have history of life threatening reaction to Tysabri? ☐ Yes ☐ No

Last Brain MRI:
Date: _____

Date and Dose of Last:
☐ Avonex: _____
☐ Betaseron: _____
☐ Lemtrada: _____
☐ Ocrevus: _____
☐ Rebif: _____
☐ Tysabri: _____

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
☐ Other _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Tysabri ☐ Dose: 300mg ☐ Frequency: every 4 weeks

Pre-Medication Orders

☒ Solu-Medrol 1000mg IV
☒ Tylenol tablet 500-1000mg PO PRN
☒ Zantac 150mg PO PRN
☒ Benadryl 25mg IV Push (SIVP)
☒ Claritin 10mg PO PRN
☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____

Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

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