

Natalizumab (Tysabri, Tyruko)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

- Patient demographics
- Office/progress notes supporting diagnosis including treatment failures
- Labs & tests supporting diagnosis
- Insurance card(s)
- Anti-JCV antibody test
- REMS / TOUCH program enrollment

DIAGNOSIS ICD-10 CODE (Provider must specify)

- | | |
|---|--|
| ☐ G35.A Relapsing-remitting multiple sclerosis | ☐ G35.B0 Primary progressive multiple sclerosis, unspecified |
| ☐ G35.B1 Active primary progressive multiple sclerosis | ☐ G35.B2 Non-active primary progressive multiple sclerosis |
| ☐ G35.C0 Secondary progressive multiple sclerosis, unspecified | ☐ G35.C1 Active secondary progressive multiple sclerosis |
| ☐ G35.C2 Non-active secondary progressive multiple sclerosis | ☐ G35.D Multiple sclerosis, unspecified ☐ Other: _____ |

PRIMARY MEDICATION ORDER

Natalizumab (Tysabri) OR natalizumab biosimilar as required by patient's insurance.

- Infuse over 60 minutes
- Flush with 0.9% sodium chloride at infusion completion
- Observe patient for one hour after the infusion is complete for the first twelve infusions.
- Refill for 12 months unless otherwise noted: _____

Dose / Frequency:

- ☐ 300mg IV every 4 weeks
☐ 300mg IV every ____ weeks

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Natalizumab

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print)

Provider Signature

Provider NPI

Date

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

- ☐ Arbor Infusion Fishers (317) 981-1772