



(natalizumab)

# TYSABRI infusion orders

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Phone \_\_\_\_\_

M \_\_\_\_\_ F \_\_\_\_\_

**DIAGNOSIS** *Please provide ICD-10 code*

Multiple Sclerosis

*(other)* \_\_\_\_\_

Crohn's Disease

**PRE-MEDICATION**

Tylenol 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

*(other)* \_\_\_\_\_

*(other)* \_\_\_\_\_

**TYSABRI ORDERS**

<b>DOSAGE</b>			<b>PATIENT WEIGHT</b>
300mg IV			lbs.
<b>FREQUENCY</b>			kg
every 4 weeks for		treatments	
<b>LAST DOSAGE OF:</b>			Date of last dose:
Avonex	Betaseron	Rebif	

**NOTES**

**ORDERING PROVIDER**

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_