Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

TYSABRI® (NATALIZUMAB) ORDER FORM

(- Required Fields)*

_____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

Locations:

-------**Oklahoma**-------
___ Tulsa

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

TYSABRI ORDER*: __

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

☐ Dosing: 300 mg IV every _____ weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Crohn's Disease
_____ Multiple Sclerosis
_____ Remitting/Relapsing MS (RRMS)
_____ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ JCV Antibody

Current MS Drug:_____

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: _____ CMP _____ CBC ____ JCV

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

REVISION DATE- 04/2020