Nevada Infusion
Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511
Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706
PH: 775-453-0667 | Fax: 775-470-8478

Tysabri Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ❑ Relapsing-Remitting MS ICD-10: G35A
- ❑ Primary-Progressive MS NOS ICD-10: G35B0
- ❑ Active Primary Progrssive MS ICD-10: G35B1
- ❑ Active Secondary Progressive MS ICD-10: G35C1
- ❑ Non-Active Primary Progressive MS ICD-10: G35B2
- ❑ Non-Active Secondary Progressive MS ICD-10: G35C2
- ❑ Secondary-Progressive MS NOS ICD-10: G35C0
- ❑ Multiple Sclerosis, NOS ICD-10:G35D
- ❑ Other_____

ICD-10:_____

ORDER FOR <u>TYSABRI (NATALIZUMAB)</u>:

- ☐ **300mg IV every 4 weeks x 1 year**
- ☐ **300mg IV every _____ weeks x 1 year**
- ☐ **Other Dose: _____ Frequency:_____ x 1 year.**

PRE-MEDICATIONS FOR OCREVUS:

- ☑ Acetaminophen 650mg PO 30 minutes prior to infusion
- ☑ Diphenhydramine 25-50 mg IV/PO 30-60 minutes to infusion
- ☑ Solumedrol 125mg IV 30 mg prior to infusion
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 01/2026

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting documentation to include past tried and/or failed therapies

☐ Supporting clinical notes and H&P (to support primary diagnosis) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ **Expanded Disability Status Scale (EDSS) score: _____**

☐ **Crohn's Disease** - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Remicade, Stelara) and/or an immunomodulator?

☐Yes OR ☐ No

If yes, which drug(s)? _____

☐ **Include labs, imaging and/or test results to support diagnosis:**

- ☐ **MRI (MS)**
- ☐ **JCV Antibody**
- ☐ **ESR/CRP (Crohn's)**

☐ **If applicable** - Last known biological therapy: _____ and last date received: _____. If the patient is switching to biologic therapies, please perform a wash out period of _____ weeks prior to starting Tysabri.

Additional REQUIRED Information:

☐ Hepatitis B screening test completed within 12 months - this includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - please include results

- ☐ Positive OR ☐ Negative
- ☐ Serum Immunoglobulin Panel (required)

*If Hepatitis B results are positive - please provide documentation of treatment or medical clearance

☐ Other medical necessity: _____

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