The Outpatient Infusion Center
a Service of Comanche County Memorial Hospital

Phone: 580-250-5899
Fax: 580-585-5472

TYSABRI ORDER FORM

PATIENT INFORMATION

Last Name: ____ First Name: ____ MI_________
HT: ___________ WT: ___________ DOB: _________________ Sex :( ) Male ( ) Female SSN:________________________________
Street Address____ City/State/Zip ____
Home Phone # _______________________________ Work # _______________________________ Cell # ________________________________

INSURANCE INFORMATION

Primary Insurance Name____ Policy ID# _________________________
Secondary Insurance Name____ Policy ID# _________________________

PHYSICIAN/FACILITY INFORMATION

Physician's Name_______________________________ Contact Name __________________________ Contact Phone # ____________________
Address ____________________________________ City/State/Zip__________________________________Fax #:________________________
DEA# ________________________________ NPI # _______________________________ State License # _______________________________

STATEMENT OF MEDICAL NECCESITY

Primary Diagnosis (ICD 10 code AND CPT code) ____
Secondary Diagnosis (ICD 10 code AND CPT code) ____

PERTINENT MEDICAL HISTORY

TB test performed? ☐ Yes ☐ No Results____ Patient diagnosed with Congestive Heart Failure? ☐ Yes ☐ No
Liver function test normal? ☐Yes ☐ No Comments____
Does the patient have venous access? ☐Yes ☐No If Yes, what type? ____
Patient previously treated with Remicade? ☐Yes ☐No If Yes, date: _____________________________________
Patient had Hep-B antigen surface antibody test? ☐Yes ☐No If Yes, date: _____________________________________

PRESCRIPTION ORDERS: TYSABRI (NATALIZUMAB)
***ALL MEDIPORTS/PORTS/VAD WILL BE FLUSHED WITH HEPARIN PER HOSPITAL PROTOCOL**
***50 mL BAG OF NORMAL SALINE WILL BE HUNG TO CLEAR ALL PATIENT LINES**

Labs Needed: ☐**CBC with differential and platelets (prior to first dose of infusion cycle)** ☐**BMP – after THIRD dose**
☐**TYSABRI test (JCV) – prior to dose SIX (code 19503 – JC polyoma virus DNA, QN real time PCR, plasma) (CPT 87799)**

PRN Flushes: ☐**10mL NS flush syringe** ☐**50mL mini-bag NS**
☐**DO *NOT* ADMINISTER HEPARIN TO THIS PATIENT****
****unless box checked, Heparin and Saline may be flushed PRN to all PICC lines, ports, midlines, and central lines**

Prescriber Notes:____
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Physician's Signature ____ **Date** __________________________ **Time** _______________

Fax completed form to the Outpatient Infusion Center at 580-585-5472. PLEASE include copies of: H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY or any other documentation supporting the use of infusion therapy, and ALL current insurance information for your referral to be processed.