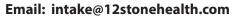
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

**Direct Phone: (844) 893-0012** 





TYSABRI ORDER FORM						
Date:		ICD-10 Code:			Therapy Status	
Patient Name:		Allergies:		☐ New Start		
Date of Birth:		Weight:kg		☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION						
Ordering Provider: Provider						
Provider NPI:			Provider Address:_			
MEDICATION ORDER						
WILDICATION ORDER						
Tysabri	infused over a minimum of protocol.  ☐ Tysabri 300mg IV every _	infused over a minimum of 60 minutes per protocol.  Tysabri 300mg IV every weeks to be infused over a minimum of 60 minutes per		tefills for one year from date f signature unless indicated below.  Refills		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  ✓ JCV Antibody
PRE-MEDICATIONS						
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:				IV   □ Dexamethasone:4mg8mg   □ Diphenhydramine:25mg50mg   □ Famotidine:20mg40mg   □ Methylprednisolone: 125mg   □ Hydrocortisone: 100mg   □ Ondansetron:4mg8mg   □ Other:		
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  By signing below, I certify that the above therapy is medic  By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my  to payors with respect to this patient and prescription order. This enrollment				y designated agent in submitting prior authorizations and other clinically required information		
Droccribor	Namo	Data		Drosoribor Mon		D-4-