Tysabri Order

(Natalizumab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP
❒ H & P Relevant to Diagnosis ❒ Current Medications
❒ Tysabri Touch Authiorization ❒ JCV lab

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS: *(USUALLY NOT INDICATED)*

Benadryl:	❒ PO	❒ IV	❒ 25mg	❒ 50mg	❒ Pre-med	❒ PRN
Acetaminophen	❒ PO		❒ 650mg		❒ Pre-med	❒ PRN

TYSABRI (NATALIZUMAB) IV DOSAGE:

Date of Last Treatment, If Continuation:

300 mg IV evert 4 weeks

Other: _____ Duration: _____

***Must be enrolled and authorized in the Tysabri Touch program.**