

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

DIAGNOSIS*

ICD-10 CODE (required)

Please complete 2nd and 3rd digits to complete ICD-10 for billing

K50.0 _____ Crohn's Disease of Small Intestine without Complications Other: _____, ICD-10 _____
 K50.1 _____ Crohn's Disease of Large Intestine without Complications
 K50.8 _____ Crohn's Disease of Both Small and Ig Int w/o Complications

INFUSION ORDERS

MEDICATION

Tysabri® (natalizumab)
 Patient enrolled in TOUCH Prescribing Program

DOSE

300mg

DIRECTIONS/DURATION

Infuse IV over 1 hour every 4 weeks x _____ months
 Observe patient for 1 hour after completion of infusion.
 If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD.

Is patient currently receiving therapy above from another facility? NO YES
 If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS:

Labs to be drawn by: Infusion Center Referring Physician

No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:

No premeds ordered at this time Diphenhydramine 25mg PO Other: _____
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS (required)

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
 - Annual TB screening to be done by: Infusion Center Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
 - Continuation labs to be done by: Infusion Center Referring Physician

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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