vitalcare® of SOUTH DALLAS

☐ Home Infusion ☐ Alternate Site of Care

TYSABRI INFUSION ORDERS

P: 945.212.3707 | **F:** 866.790.3580

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.790.3580

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Multiple Sclerosis (ICD-10 code: G35)

MS Type: ☐ Relapsing-Remitting ☐ Secondary-Progressive ☐ Clinically Isolated

☐ Crohn's Disease (ICD-10 code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Tysabri

☐ 300mg IV every 4 weeks x 1 year

☐ 300mg IV every _____ weeks x 1 year

☐ Other: _____

Pre-Medication Orders: ☐ Tylenol 1000mg PO ☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IVP

☐ Solu-Cortef _____ mg IVP

☐ Other: _____

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Vital Care ☐ Referring Provider

Other orders: _____

Home IV Biologic Ana-kit Orders (adult):

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV
- 0.9% NS 1000mL bolus per protocol PRN

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Vital Care of South Dallas* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Vital Care selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____

vitalcare® of SOUTH DALLAS

COMPREHENSIVE SUPPORT FOR TYSABRI THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Prescriber is a TOUCH authorized provider
- ☐ Patient enrolled in TOUCH Program
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to therapy
  - ☐ *MS* - 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 ☐ No If yes, which drug(s)? _____
- ☐ Include labs 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 patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Tysabri.
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **JCV Antibody - attach results**
  ☐ **Positive** ☐ **Negative**

Vital Care will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (866) 790-3580 or call (945) 212-3707 for assistance