PARAGON INFUSION CENTERS

TYSABRI (NATALIZUMAB)
INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

J Code: J2323 Diagnosis: ☐ Multiple Sclerosis ICD-10 Code: _____

☐ Crohn's Disease ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Patient's TOUCH authorization attached

☐ Last MRI attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

TYSABRI ORDERS

Tysabri Intravenous Dose: 300mg

Frequency: ☐ Once every 4 weeks x _____ doses

Protocol Pre-Medication Orders: Tylenol 1000mg PO, and Antihistamine 25mg PO

** Date of last ☐ Rebif ☐ Betaseron ☐ Avonex dose: _____

Additional Instructions:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc.and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta

PARAGONHEALTHCARE.COM