Cumberland Vital Care

Fax Referral To:
(931) 456-4857

Direct Phone: (931) 456-0680

CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

TYSABRI ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____lbs OR _____kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

☐ Tysabri

☐ Tysabri 300mg IV every four weeks to be infused over a minimum of 60 minutes per protocol.

☐ Tysabri 300mg IV every _____weeks to be infused over a minimum of 60 minutes per protocol.

Refills x one year from date of 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: _____325mg _____500mg _____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: _____ 25mg _____50mg
- ☐ Famotidine: _____ 20mg _____40mg
- ☐ Ibuprofen: _____200mg _____400mg _____600mg
- ☐ Ondansetron: _____ 4mg _____8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: _____4mg _____8mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

Prescriber Name _____ Date _____

Substitution Allowed:

Prescriber Name _____ Date _____