

# Tysabri® Referral Form



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Patient Information		
Patient Name:		Patient DOB:
Referral Status		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Restart	<input type="checkbox"/> Medication/Order Change
		<input type="checkbox"/> D/C Infusions
Diagnosis and ICD 10 Code		
<input type="checkbox"/> Relapsing forms of Multiple Sclerosis	ICD 10 Code: <b>G35</b>	
<input type="checkbox"/> Crohn's disease	ICD 10 Code:	
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:	
Supporting Documentation		
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis	
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests including Anti-JCV antibodies	
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Current Medication List	
Medication Orders		
<input type="checkbox"/> Tysabri® 300 mg IV over <b>60</b> minutes every <b>4</b> weeks		
<input type="checkbox"/> Tysabri® 300 mg IV over _____ minutes every _____ weeks		
Notes (Additional Info)		
<b>Premedication, adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.</b>		
Prescriber Information		
Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: <small>(Order is valid for one year)</small>
<p>My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.</p>		
<b>Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</b>		

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