TYSABRI (NATALIZUMAB) Referral Order Form — FAX (877) 637-6691

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* ____________

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: ____________________ Date: __________

DOB: ______________ SS# ______________

Phone # ______________

Email: ______________________________

PHYSICIAN INFORMATION

Referring Physician: ______________________________

Practice Address: ______________________________

____

Office Contact: ______________________________

Contact Phone # __________ Contact Fax # __________

NPI / TIN: ______________ ______________

TYSABRI MEDICATION ORDERS

Dosing: ☐300 mg Frequency: ☐ IV every 4 weeks. Refills: __________

INDICATION/DIAGNOSIS

☐Crohn's Disease
☐Multiple Sclerosis
☐RRMS (Remitting/Relapsing MS)

***ICD-10 ____________________ required**

______________________________ __________
Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along w/ any therapies tried and outcomes) ☐Current Medication List ☐History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ JCV Antibody ☐ CMP (w/in past 3 months) ☐ CBC with differential (w/in past 3 months)

APPOINTMENT DATE & TIME: ______________________________

FOR OFFICE USE ONLY