



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

PHYSICIAN INFORMATION

Name: _____
 DOB: _____ SS# _____
 Phone # _____
 Email: _____

Referring Physician: _____
 Practice Address: _____
 Office Contact: _____
 Contact Phone # _____ Contact Fax # _____
 NPI / TIN: _____

TYSABRI MEDICATION ORDERS

Dosing: 300 mg Frequency: IV every 4 weeks.

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

- K50.90 Crohn's disease unspecified, without complications
- G35 Relapsing MS
- Multiple Sclerosis
- Other (please specify in notes)

*ICD-10 _____ required

 Referring Physician's Signature

 Date

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