

PROVIDERS: Please include the following to expedite the order:

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, JC Virus Results

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): G35.A G35.C1 G37.9 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- Verify patient is enrolled and authorized in TOUCH program
- JC Virus Results (list results & attach clinicals)

THERAPY ADMINISTRATION

- Natalizumab Intravenous Infusion
- Dose: 300mg
Frequency:
 Every 4 weeks
 Other: _____
- Refills: Zero / for 12 months / _____
(if not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

- Diphenhydramine 25mg / 50mg PO / IV
- Acetaminophen 500mg / 650mg / 1000mg PO
- Other: _____
- Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) _____ Provider Signature _____ Date _____

- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.