Local Infusion

MYLOCALINFUSION.COM

TYRUKO (NATALIZUMAB-SZTN) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Relapsing-remitting multiple sclerosis (RRMS), ICD 10: G35.A
❑ Active secondary progressive multiple sclerosis (SPMS), ICD 10: G35.C1
❑ Clinically isolated syndrome, ICD 10: G36.9
❑ Moderately to severely active Crohn's disease, ICD 10: K50.0
❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tyruko	300 mg	IV	❑ Every 28 days ❑ Other: _____

LABS / SPECIAL INSTRUCTIONS

❑ Check if JCV (JC Virus Antibody) labs should be drawn and monitored by the infusion center.
Timeframe: _____