Hy-Vee health™

TYSABRI
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ______________________ **DOB:** __________ **Phone:** __________

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** __________

Medical Information

Diagnosis: Multiple sclerosis **(ICD-10 Code:** G35)

MS Type: Relapsing-Remitting Secondary-Progressive Clinically Isolated

Crohn's disease **(ICD-10 Code:** ______________**)**

Patient Weight: __________ lbs. (required) **Allergies:** ______________________

Therapy Order

Tysabri:

300 mg IV every 4 weeks x1 year 300 mg IV every __________ weeks x1 year

Other: ______________________

Premedication orders: Tylenol 1000 mg PO Cetirizine 10 mg PO

Diphenhydramine 25 mg PO Loratadine 10 mg PO

Additional premedication orders: Solu-Medrol __________ mg IVP Solu-Cortef __________ mg IVP

Other: ______________

Lab Orders: ______________________

Frequency: Every infusion Other: ______________

Required labs to be drawn by: Hy-Vee Health Referring Provider

Additional orders: ______________________

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: ______________ **Signature:** ______________ **Date:** __________

Provider NPI: __________ **Phone:** __________ **Fax:** __________ **Contact Person:** __________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ______________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other __________

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COMPREHENSIVE SUPPORT FOR TYSABRI THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Prescriber is a TOUCH authorized provider

Patient enrolled in TOUCH program

Include patient demographic information and insurance information

Include patient's medication list

Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to therapy

MS – Expanded Disability Status Scale (EDSS) score: ______________________

Crohn's disease – Does the patient have a contraindication/intolerance or failed trial to at least 1 biologic (i.e., Remicade, Stelara) and/or an immunomodulator?

Yes No

If yes, which drug(s)? ______________________

Include labs and/or test results to support diagnosis

MRI (MS)

JCV Antibody

ESR/CRP (Crohn's)

If applicable – Last known biological therapy: ______________ and last date received:

______________. If patient is switching to biologic therapies, please perform a washout

period of ______________ weeks prior to starting Tysabri.

Other medical necessity: ______________________

Required Prescreening

JCV Antibody – attach results

Positive **Negative**

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

HY-VEEHEALTHINFUSION.COM

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