Hy-Vee health INFUSION CARE

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 _____

HY-VEEHEALTHINFUSION.COM

Hy-Vee health INFUSION CARE

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