



Tysabri Order

Phone: (346) 708-5160
 Fax: (888) 963-8103

www.biotekrx.com

PATIENT INFORMATION (Complete or fax existing chart)			PRESCRIBER INFORMATION		
Patient Name:			Prescriber Name:		
Address:			State License:	NPI#:	
City, State, Zip:			DEA:	Phone:	
Phone:	2 nd Phone:		Address:	Fax:	
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		City, State, Zip:		
Weight:	Ht:	ICD-10 code:	Contact Person:		
Diagnosis:			Phone:		
Allergies:					
INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)					
Primary Insurance:			RX Card (PBM):		
City, State, Zip:			BIN:	PCN:	
Plan#	Group#		City, State, Zip:		
Phone:			Plan#	Group#	
CLINICAL INFORMATION					
Has the patient been tested for JCV virus? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, what were the results?		
Previous tried and failed therapies:					
PRESCRIPTION / ADMINISTRATION					
Medication	Dose			Refills	
Tysabri	<input type="checkbox"/> 300 mg IV	<input type="checkbox"/> Every 4 weeks	<input type="checkbox"/> Every 6 weeks	#	
		<input type="checkbox"/> Every 8 weeks	<input type="checkbox"/> Every 12 weeks		
SIGNATURE					
X _____			Date: _____		
(Product Substitution Permitted)					

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