



Tysabri Order

Phone: (877)-246-9104

Fax: (800) 783-9146

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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