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:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ 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? ☐ Yes ☐ No	If yes, what were the results?
Previous tried and failed therapies:	

PRESCRIPTION / ADMINISTRATION			
Medication	**Dose**		**Refills**
Tysabri	☐ 300 mg IV	☐ Every 4 weeks ☐ Every 6 weeks	#
		☐ Every 8 weeks ☐ Every 12 weeks	

SIGNATURE

x _____ Date: _____
(Product Substitution Permitted)

Fax completed form to: (800)783-9146- Thank you for using BioTek reMEDys®