LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Relapsing – Remitting Multiple Sclerosis	ICD 10 Code: G35
☐ Secondary progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Primary Progressive Multiple Sclerosis	ICD 10 Code: G35
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other: _____	ICD 10 Code: _____

List of tried and failed therapies, including duration of treatment:
_____

If MS, current MS treatment and end of current therapy date: _____

Is your patient currently enrolled in TOUCH (FDA REMS) program? ☐ Yes ☐ No

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and tests supporting primary diagnosis
☐ Prior authorization with reference number	☐ Hepatitis B test results: HBsAg & HepB Core w/reflex IgG and IgM
☐ Anti-JCV antibodies test results	*Pt may be required to submit a pregnancy test prior to treatment

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____

Dosing	☐ J2323 Tysabri 300mg IV every 4 weeks ☐ J2323 Tysabri 300mg IV every _____ weeks

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____mg PO PRN	☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ Benadryl _____mg PO or IV	☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Methylprednisolone _____ slow IV push	☐ Other: _____ Date:_____
☐ Other: _____	

ADDITIONAL ORDERS/INFORMATION

☐ Urine pregnancy test prior to first infusion

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – TYSABRI (NATALIZUMAB)