



Tysabri Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION	
Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. PHYSICIAN INFORMATION	
Physician's Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State: Zip:
Office contact:	Email:
Office phone:	Office fax:

3. DIAGNOSIS INFORMATION (and year of diagnosis)	
Multiple Sclerosis (MS) (_____)	ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION	
Please submit copies of the front and back or primary and secondary insurance cards with this referral.	

5. PRESCRIPTION INFORMATION (requires new order every 12 months)	
TYSABRI	PRE-MEDICATIONS N/A
Administer 300mg intravenous infusion q _____ weeks over 1 hour	Acetaminophen 500mg 650mg 1000mg PO
	Cetirizine (Zyrtec) 10mg PO (or other non-sedating anti-histamine)
Vital signs per LUX Protocol	Diphenhydramine (Benadryl) 25mg 50mg
Anaphylaxis & Hydration Management per Lux Protocol	PO IV (requires driver)
	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
	Prednisone _____ mg PO
	Other: _____
	POST-MEDICATIONS N/A
	Acetaminophen 500mg 650mg 1000mg PO
	Prednisone _____ mg PO
	Other: _____

6. SIGNATURE (required)	
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PHYSICIAN'S SIGNATURE DATE