CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

TYSABRI (natalizumab) infusion orders

Patient Name _____ DOB _____

Phone _____ M ◉ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis
☐ _____ Crohn's Disease
☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Quzyttir 10mg IVSP over 1-2 min
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

TYSABRI ORDERS

DOSAGE

☐ 300mg IV ☐ _____

PATIENT WEIGHT

_____ lbs.
_____ kg

FREQUENCY

every __ weeks for _____ treatments

LAST DOSAGE OF:

◉ Avonex ○ Betaseron ○ Rebif Date of last dose: _____

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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