

# Natalizumab Biosimilars

Provider Order Form Rev. 05/2026

Please fax completed referral form & all required documents to (833) 786-0025



## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  in  cm  
Patient Status:  New to Therapy  Dose or Frequency Change  Order Renewal

**INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**

## DIAGNOSIS\*

**\*ICD 10 Code  
Required**

- Relapsing-Remitting Multiple Sclerosis, G35.A  Crohn's Disease (K50.00-K50.919), ICD10 \_\_\_\_\_  
 Active Secondary Progressive Multiple Sclerosis, G35.C1  
 Demyelinating Disease of CNS, unspecified, G37.9 [for Clinically Isolated Syndrome]

## INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Natalizumab biosimilars available: <input type="checkbox"/> Tysabri® (natalizumab) <input type="checkbox"/> Tyruko® (natalizumab-sztn) <input type="checkbox"/> Patient is enrolled in RMS Program	300 mg	<input type="checkbox"/> Infuse IV over 1 hour every 4 weeks x _____ months *Observe patient for 1 hour after completion of infusion. <input type="checkbox"/> If no hypersensitivity reaction observed with first 12 infusions, then post-infusion observations as directed by MD.

Is patient currently receiving therapy above from another facility?

Yes  No

If yes, Facility Name: \_\_\_\_\_

Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

## PRE-MEDICATION ORDERS

- No premeds ordered at this time  
 Acetaminophen 650mg PO  Diphenhydramine 25mg PO  
 Methylprednisolone 40mg IVP -OR-  Hydrocortisone 100mg IVP  
 Other: \_\_\_\_\_

## LAB ORDERS

- Labs to be drawn by:  Infusion Center  Referring Physician  
 No labs ordered at this time  Other: \_\_\_\_\_  
 CBC q \_\_\_\_\_  CMP q \_\_\_\_\_  CRP q \_\_\_\_\_  
 ESR q \_\_\_\_\_  LFTs q \_\_\_\_\_  JCV antibody q: \_\_\_\_\_

## REFERRING PHYSICIAN INFORMATION

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_ TIN: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

## LAB AND TEST RESULTS (required)

- JC virus (JCV) antibody testing (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by:  Infusion Center  Referring Physician
- Patient must be enrolled in the REMS Prescribing Program. Provide copy of authorization to infuse.

## PRIOR FAILED THERAPIES

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
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