arise infusion
THERAPY SERVICES

*Advanced Treatment for Osteoporosis and Inflammatory Diseases*

WHEATON • ROCKVILLE • OLNEY • CHEVY CHASE • FREDERICK • WASHINGTON, DC

# TYSABRI (Natalizumab) INFUSION REFERRAL CHECKLIST

Patient Name: _____ Date: _____

DOB: _____

Referring Physician: _____ Referring Office Contact:_____

Phone: _____ Fax: _____ Address: _____

Diagnosis: _____ ICD Code: _____

Please include the type of multiple sclerosis the patient has been diagnosed with:

☐ Relapsing-remitting MS ☐ Secondary-progressive MS ☐ Primary-progressive MS ☐ Progressive-relapsing MS

Special Instructions: _____

_____

Please send the following documents and records:

- Patient Demographics – Including the preferred contact number for patient
- Copy of the patient's insurance card(s) – Front AND Back
- Tysabri order signed and dated by referring physician
- Three most recent office notes (One must include discussion of Tysabri) and consult note
- Most recent labs to include CMP, CBC and JCV Antibody tests
- Most recent MRI report
- Medication History
- If this is a continuation of treatment, include the last infusion note

**PLEASE FAX TO 301-424-3590 USING THIS FORM AS THE COVERSHEET**

www.ariseinfusion.com
CENTRAL CALL CENTER: 240-514-5000
FAX: 301-424-3590