TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Tysabri Order

Return Completed Form To:
888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)				PRESCRIBER INFORMATION	
Patient Name:				Prescriber Name:	
Address:				State License:	NPI#:
City, State, Zip:				DEA:	Phone:
Phone:		2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female			City, State, Zip:	
Weight:	Ht:	ICD-10 code:		Contact Person:	
Diagnosis:				Phone:	
Allergies:					

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)			
Primary Insurance:		RX Card (PBM):	
City, State, Zip:		BIN:	PCN:
Plan#	Group#	City, State, Zip:	
Phone:		Plan#	Group#

CLINICAL INFORMATION	
Has the patient been tested for JCV virus? ☐ Yes ☐ No	If yes, what were the results?
Previous tried and failed therapies:	

PRESCRIPTION / ADMINISTRATION				
Medication	**Dose**			**Refills**
Tysabri	☐ 300 mg IV	☐ Every 4 weeks	☐ Every 6 weeks	#
		☐ Every 8 weeks	☐ Every 12 weeks	

SIGNATURE

x ____ Date: ______________________
(Product Substitution Permitted)

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