Office Administration Request Form for Tysabri® (Natalizumab)
Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. ***Form must be completed for processing***

Patient Name: ______________________ Patient ID#: ______________________

Address: ______________________ Apt # or Suite #: __________ City: ______________________

State: _________ Zip Code: ___________ Phone #: ______________________ Birthdate: ______________________

Physician Name: ______________________ NPI #: ______________________

Address: ______________________ Apt # or Suite #: ________ City: ______________ State: ______ Zip Code: _________

Contact Person: ______________________ Phone #: ______________ Fax #: ______________

Physician Signature: ______________________________________

Medical Condition:	☐ Relapsing/Remitting MS ☐ Crohn's Disease ☐ Primary Progressive MS ☐ Secondary Progressive MS ☐ Chronic – Progressive Relapsing ☐ Other: ______________________

Is the member currently enrolled in the TOUCH™ program (please check): ❑ Yes ❑ No
Does the member have a history of progressive multifocal leukoencephalopathy (PML): ❑ Yes ❑ No

Start of Date of Treatment::__________________ Dose:______________ SIG:______________________ Refills:____________

Previous Medication Treatment History

Medication	**Start/End Date**	Directions/Frequency	Reason for discontinuing treatment
Rebif® (Interferon beta-1a)			
Copaxone® (Glatiramer acetate)			
Humira® (Adalimumab)			
Oral corticosteroids			

Medical Reasons for selecting Tysabri® instead of another treatment option: (Attach additional information if necessary):
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For a diagnosis other than Crohn's Disease or Multiple Sclerosis: Rationale for choosing this treatment, please include all applicable documentation: ____

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