

**Office Administration Request Form for Tysabri® (Natalizumab)**  
 Fax to PerformRx Pharmacy Services at 215-937-5018, or to speak to a representative call 800-588-6767. *Form must be completed for processing*



Patient Name: \_\_\_\_\_ Member 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: \_\_\_\_\_

<b>Medical Condition:</b>	<input type="checkbox"/> Relapsing/Remitting MS	<input type="checkbox"/> Crohn's Disease
	<input type="checkbox"/> Primary Progressive MS	<input type="checkbox"/> Secondary Progressive MS
	<input type="checkbox"/> Chronic – Progressive Relapsing	
	<input type="checkbox"/> 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):  
 \_\_\_\_\_  
 \_\_\_\_\_

**For a diagnosis other than Crohn's Disease or Multiple Sclerosis:** Rationale for choosing this treatment, please include all applicable documentation:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

