



Tysabri® (natalizumab) Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND
FAX TO: 1-866-239-5873 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____
 Date of Birth (mm/dd/yyyy): ____/____/____

Phone #1: _____ Phone #2: _____
 Allergies: _____ No Known Allergies
 Health Conditions: _____
 Expected Start Date: ____/____/____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____

Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

- In Office Delivery Home Delivery for Self Injection/Administration
 Home Delivery for Home Health Administration

Contact: _____
 Phone #: _____
 Address: _____

Other: _____

Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____
 Insured: _____
 ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Secondary: _____
 Insured: _____
 ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____

Office Contact: _____
 NPI #: _____ DEA #: _____
 Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING RX FORM -OR- TAPE RX HERE

Date: ____/____/____	
Rx	
Drug Name/Form/Strength	Directions for Use
<input type="checkbox"/> Tysabri® 300mg/mL 15mL SDV	INFUSE INTRAVENOUSLY PER PRESCRIBING INFORMATION EVERY 4 WEEKS
Other:	Quantity: _____ Refills: _____
Needles Gauge: _____ Inches: _____ Quantity: _____ Refills: _____	Syringes Volume: _____ Inches: _____ Quantity: _____ Refills: _____
X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted	X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted