

Tysabri® (natalizumab) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code (MS-SEE BELOW):	ICD-10 Description:	Last Treatment Date:
		Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

TYSABRI ADMINISTRATION

300 mg IV every 4 weeks

LABORATORY ORDERS

CBC w/ diff every _____

CMP every _____

Stratify JCV Antibody Test every 6 months

Vitamin D-25-OH every 12 months

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25 mg 50 mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____

REQUIRED ICD-10 CODE

G35.A Relapsing-remitting multiple sclerosis

G35.B0 Primary progressive multiple sclerosis, unspecified

G35.B1 Active primary progressive multiple sclerosis

G35.B2 Non-active primary progressive multiple sclerosis

G35.C0 Secondary progressive multiple sclerosis

G35.C1 Active secondary progressive multiple sclerosis

G35.C2 Non-active secondary progressive multiple sclerosis

G35.D Multiple sclerosis, unspecified

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

JCV Antibody

Current MS Drug _____

Provider Name (Print)

Provider Signature

Date

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679

Michigan: 833-957-2188

New York: 800-540-1852

Texas: 469-340-0044

Connecticut: 203-724-4838

Minnesota: 763-290-0903

Ohio: 216-400-0674

Virginia: 804-500-5941

Florida: 904-930-4211

Nevada: 702-489-5744

Oklahoma: 918-770-4421

Wisconsin: 414-600-5383

Massachusetts: 781-202-1629

New Jersey: 609-955-3711

Pennsylvania: 215-399-9244

Revision Date 10/2025