

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.

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) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____

**Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.*

NATALIZUMAB ADMINISTRATION: Payors may require patients start therapy with a natalizumab biosimilar. Choose ONE of these two options:

Infuse **natalizumab** or **natalizumab biosimilar** as required by patient's insurance.

Do not use biosimilar (subject to prior authorization).

Dose: 300 mg IV every 4 weeks

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

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	