Office Administration Request Form for Tysabri® (Natalizumab)
Fax to PerformRx Pharmacy Services at **888-981-5202**, or to speak to a representative call 866-610-2774. *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: ____

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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