PATIENT DETAILS	*Affix patient Addressograph if available
SURNAME: _____	FIRST NAME(S): _____
DATE OF BIRTH: _____/_____/_____	MRN: _____

NDMS Multiple Sclerosis Patient Eligibility Form Natalizumab (Tysabri®)

Form must be completed in full and saved securely in the patient's medical record for audit purposes only

TREATMENT	HSE APPROVED INDICATION	ICD10	Protocol Code
Natalizumab (Tysabri®)	Natalizumab (Tysabri®) is indicated as single disease modifying therapy in adults with highly active relapsing remitting multiple sclerosis for the following patient groups:		
	Patients with highly active disease despite a full and adequate course of treatment with at least one disease modifying therapy (DMT) (*for exceptions and information about washout periods see AIDMP Protocol MS101a&b and the SPC)*	G35	**MS101a**
	OR		
	Patients with rapidly evolving severe relapsing remitting multiple sclerosis defined by 2 or more disabling relapses in one year, and with 1 or more Gadolinium enhancing lesions on brain MRI or a significant increase in T2 lesion load as compared to a previous recent MRI	G35	**MS101b**

ELIGIBILITY	YES	NO
Indication as per protocol MS101a,b		
Eligibility criteria in protocol MS101a,b have been met		
EXCLUSIONS	**YES**	**NO**
All exclusion criteria laid out in protocol MS101a,b have been considered.		

PREVIOUS MEDICATION(S) FOR MULTIPLE SCLEROSIS			
Name of Medicine (in order of use; 1. = first line etc.)	Reason for change in treatment (please tick)		
	Adverse Event	Loss of Response	Other Reason
1.			
2.			
3.			
4.			
5.			

PRESCRIBER DETAILS	
Prescriber Name	
Medical Registration Number	
ELIGIBILITY FORM COMPLETED BY	
Name	
Date	