

VA Natalizumab (Tysabri®) Clinical Monitoring Program
Initial Registry Information

Date of Evaluation: __/__/____

VAMC Healthcare Provider: _____
 VAMC Provider Phone #: _____ Email: _____
 VAMC Location (City): _____ Facility # _____

Name of Patient (first, last name): _____

Date of Birth: __/__/____

Patient's Four Digit VA Code: ____

Complete at the initial visit prior to starting natalizumab

1. Sex: Male: Female:

2. Race:

- | | |
|------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other _____ |

3. Ethnicity: Hispanic or Latino Non-Hispanic or Latino

4. Year of onset of initial MS symptoms: _____

5. Number of relapses over the past year (prior to starting natalizumab): _____

6. Indicate the MS disease modifying therapies used in the past:

- a. Interferon-beta:
 - i. Avonex®: total months on therapy: _____
 - ii. Betaseron®: total months on therapy: _____
 - iii. Rebif®: total months on therapy: _____
- b. Glatiramer acetate: Copaxone®: total months on therapy: _____
- c. Mitoxantrone: Novantrone®: total months on therapy: _____
- d. Chemotherapy/Other: _____ (name medication) total months on therapy _____

7. Indication(s) for Natalizumab (Tysabri®), check all that apply:

- | | |
|---------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> Side effects from interferon-beta | <input type="checkbox"/> Inadequate response despite interferon-beta therapy |
| <input type="checkbox"/> Side effects from glatiramer acetate | <input type="checkbox"/> Inadequate response despite glatiramer acetate therapy |
| <input type="checkbox"/> Other: _____ | |

8. MS Disease Subtype: Relapsing-remitting Secondary-progressive with relapses Progressive-relapsing

9. MS Disability at time of evaluation:

a. Expanded Disability Status Scale (Kurtzke J, et al *Neurology* 1983;13:1444) check box:

- | | | | | | | | | |
|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 2.0 | <input type="checkbox"/> 3.0 | <input type="checkbox"/> 4.0 | <input type="checkbox"/> 5.0 | <input type="checkbox"/> 6.0 | <input type="checkbox"/> 7.0 | <input type="checkbox"/> 8.0 | <input type="checkbox"/> 9.0 |
| <input type="checkbox"/> 1.0 | <input type="checkbox"/> 2.5 | <input type="checkbox"/> 3.5 | <input type="checkbox"/> 4.5 | <input type="checkbox"/> 5.5 | <input type="checkbox"/> 6.5 | <input type="checkbox"/> 7.5 | <input type="checkbox"/> 8.5 | <input type="checkbox"/> 9.5 |
| <input type="checkbox"/> 1.5 | | | | | | | | |

or

b. Provider Determined Disease Steps (Hohol M, et al *Neurology* 1995;45:251) check box:

- | | |
|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> 0-Normal | <input type="checkbox"/> 4-Late Cane |
| <input type="checkbox"/> 1-Mild Disability | <input type="checkbox"/> 5-Bilateral Support |
| <input type="checkbox"/> 2-Moderate Disability | <input type="checkbox"/> 6-Wheelchair |
| <input type="checkbox"/> 3-Early Cane | |

Please FAX this form to: Alicia Sloan, MPH, LICSW, Research Coordinator

MS Center of Excellence-West, FAX: **206-277-4827**, VOICE: 206-277-3593

Questions? Email Alicia.Sloan@va.gov

Visit the MSCoE website at www.va.gov/ms