

TYSABRI (NATALIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral
 ☐ Dose or Frequency Change
 ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

- | | |
|---|---|
| ☐ Relapsing-remitting multiple sclerosis (G35.A) | ☐ Primary progressive multiple sclerosis, unspecified (G35.B0) |
| ☐ Primary progressive multiple sclerosis, active (G35.B1) | ☐ Primary progressive multiple sclerosis, non-active (G35.B2) |
| ☐ Secondary progressive multiple sclerosis, unspecified (G35.C0) | ☐ Secondary progressive multiple sclerosis, active (G35.C1) |
| ☐ Secondary progressive multiple sclerosis, non-active (G35.C2) | ☐ Multiple sclerosis, unspecified (G35.D) |

REQUIRED DOCUMENTATION

- | | |
|---|---|
| ☐ This signed order form by the provider | ☐ H&P and Clinical/Progress notes supporting primary diagnosis |
| ☐ Patient demographics AND insurance information | ☐ Labs and Tests supporting primary diagnosis |
| ☐ Pregnancy Test (if applicable) | ☐ Hepatitis B Test Results: HBsAg & total HepB Core antibody |
| ☐ Tried and Failed therapies | ☐ Anti-JCV antibodies test result |

If MS, current MS treatment and end of current therapy date: _____

Is your patient currently enrolled in the TOUCH (FDA REMS) program? ☐ Yes ☐ No

MEDICATION ORDERS

Dosing: ☐ Tysabri 300 mg IV every 4 weeks
☐ Tysabri 300 mg IV every _____ weeks
☐ Patient has had 12 infusions without evidence of hypersensitivity and does not require post-infusion observation

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

*(if not indicated, order will expire 1 year from date signed)

- ☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATIONS ORDERS

- | | |
|--|--|
| ☐ Acetaminophen 650mg PO prior to infusion | ☐ Diphenhydramine 25mg PO prior to infusion |
| ☐ Methylprednisolone _____mg Slow IV Push prior to infusion | ☐ Other: _____ |

EMERGENCY MEDICATIONS

- ☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (A/C/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____