Natalizumab (Tysabri)

Provider Order Form rev. 02/08/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Multiple Sclerosis: ☐ RRMS ☐ PPMS ☐ SPMS

Crohn's Disease: Other: Description:

REQUIRED INFORMATION

☑ JCV results _____ Date: _____

THERAPY ADMINISTRATION & DOSING

☑ Administer Tysabri 300 mg in 100 ml 0.9% sodium chloride intravenously over 60 minutes.

☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion. After 12 infusions without an infusion reaction, use clinical judgement and determine if observation period is still needed.

FREQUENCY *(Choose One)*

☐ Every 4 weeks

☐ Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Prior to every appointment:

- Confirm patient is authorized in TOUCH Prescribing Program
- Provide and review patient with Tysabri Patient Medication Guide
- Complete Pre-Infusion Patient Checklist

☑ Hold infusion and notify provider if patient reports fever or signs/symptoms of illness/active infection, or signs of thrombocytopenia.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI, documentation of TOUCH enrollment

Required Labs: CRP, ESR, JCV, TB, Hep B

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.