

Natalizumab (Tysabri)

Provider Order Form rev. 3/1/2023



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- Verify patient is enrolled and authorized in TOUCH program. Complete pre-infusion checklist at www.touchprogram.com; notify provider of any contraindications to infusion
- Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

- STRATIFY JCV Antibody ELISA with reflex to inhibition assay, JCV with index
 - at each dose every _____
- CBC at each dose every _____
- CMP at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

(ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

- Natalizumab** (Tysabri) in 100ml 0.9% sodium chloride, intravenous infusion
 - Dose: 300mg
 - Frequency: every 4 weeks / other: _____
 - Infuse over 60 minutes
- Flush with 0.9% sodium chloride at infusion completion
- Patient required to stay for 1-hour observation post infusion
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date