

Tysabri (Natalizumab)

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

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

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

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

PRE-MEDICATION ORDERS

- 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 INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
 Ordering Provider: _____ Provider NPI: _____
 Referring Practice Name: _____ Phone: _____ Fax: _____
 Practice Address: _____ City: _____ State: _____ Zip Code: _____

 Provider Name (Print) Provider Signature Date