

NATALIZUMAB (TYSABRI®) PRESCRIBER ORDER FORM				
Patient Name:		Date of Birth:		Gender:
Address:				
Patient Phone:		Height:	☐ inches ☐ cm	Weight: ☐ lbs. ☐ kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Is this the first dose?	☐ Yes ☐ No – Date of last dose: _____			
Natalizumab (Tysabri®) Prescription				
Natalizumab (Tysabri®) 300 mg refill as directed x 1 year Infuse 300 mg IV over 60 minutes every 4 weeks.				
Ancillary Orders				
Anaphylaxis Kit Dosage: ▪ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN. ▪ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. ▪ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.				
Medication Orders ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline. ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline. ☐ Loratadine 10 mg PO 30 min before infusion. Patient may decline. ☐ Methylprednisolone sodium succinate 40 mg IV push 20 minutes prior to infusion. ☐ Other: _____				
IV Flush Orders ☐ <u>Peripheral:</u> NS 2 to 3 mL pre-/post-use. ☐ <u>Implanted Port:</u> NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.				
Lab Orders ☐ No labs ordered at this time. ☐ Other: _____				
Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.				
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
Prescriber Signature:			Date:	
Prescriber Information				
Prescriber Name:		Phone:		Fax:
Address:		NPI:		
City, State:	Zip:	Office Contact:		
Fax completed form, insurance information, and clinical documentation to: 713-983-4647				
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