


NATALIZUMAB (TYSABRI®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:		Date of Birth:		
	Address:				
	Patient Phone:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:

Clinical Information

Primary Diagnosis Description:			ICD-10 Code:		
Is this the first dose? <input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:		Hepatitis B Status:		Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
TB Status:	<input type="checkbox"/> PPD (negative) – date:		<input type="checkbox"/> Active TB		
	<input type="checkbox"/> Last chest x-ray – date:		<input type="checkbox"/> Unknown		
	<input type="checkbox"/> Past positive TB infection, course taken:				

Natalizumab (Tysabri®) Prescription

Natalizumab (Tysabri®) 300 mg refill as directed x 1 year

Infuse 300 mg IV over 60 minutes every 4 weeks.
Discontinue after 12 weeks if no therapeutic response.

Ancillary Orders

Anaphylaxis Kit
→ Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

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 40 mg IV push 20 minutes prior to infusion.
- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: 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.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature:	Date:
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Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	

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