NATALIZUMAB (TYSABRI®) PRESCRIBER ORDER FORM

Ascension at Home | TOGETHER WITH COMPASSUS®
Appleton and Oak Creek, WI
t 800-648-8055 f 414-563-0600

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

Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

CLINICAL INFORMATION

Primary Diagnosis Description: **ICD-10 Code:**

Is this the first dose?
☐ Yes – date of first dose: _____
☐ No – date of next dose due: _____

Hepatitis B Status:
Titer Date: _____
☐ Positive ☐ Negative
☐ Prescriber declines based on patient assessment

TB Status:
☐ PPD (negative) – date: _____
☐ Last chest x-ray – date: _____
☐ Past positive TB infection, course taken: _____
☐ Active TB
☐ Prescriber declines based on patient assessment

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

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg PO or IV/IM. May repeat additionally 25mg PO or IV PRN.
- Normal saline 500 mL (> 30 kg) or 250 mL (< 30 kg) IV at KVO rate PRN anaphylaxis. Patient < 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

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 initiate IV access for administration of doses in the home or alternate care setting. Access to be discontinued upon completion of infusion. 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:** _____

PRESCRIBER INFORMATION

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