AIC NORTH
SPECIALTY INFUSION CENTER
989-619-6253 855-857-3834

INFUSION ORDERS-TYSABRI (NATALIZUMAB)

PATIENT INFORMATION

Name: ______________________ DOB: __________ Height: ________ Weight: ________
Address: ______________________ Phone: __________ Allergies: ________
City, State, Zip: ______________________ Email: ______________________

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD-10 CODE

☐ Relapsing-Remitting Multiple Sclerosis — ICD-10 Code: G35.1
☐ Secondary Progressive Multiple Sclerosis — ICD-10 Code: G35.3
☐ Moderate to Severe Crohn's Disease — ICD-10 Code: K50.90
☐ Diagnosis: ______________________ ICD-10 Code: __________

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Pregnancy Test (if applicable)
☐ Tried and Failed therapies
☐ Clinical/Progress notes supporting primary diagnosis
☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg & total HepB Core antibody
☐ Anti-JCV antibodies test result

If MS, current MS treatment and end of current therapy date: ______________________
Is your patient currently enrolled in the TOUCH (FDA REMS) program? ☐ Yes ☐ No

MEDICATION ORDERS

Dosing
☐ Tysabri 300 mg IV every 4 weeks
☐ Tysabri 300 mg IV every _______ weeks
☐ Patient has had 12 infusions without evidence of hypersensitivity and does not require post-infusion observation

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: ____________
(if not indicated, order will expire 1 year from date signed)

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
☐ RN to flush and lock VAD/CVAD per company protocol

PREMEDICATIONS ORDERS

☐ Acetaminophen 650mg PO, 30-60 minutes prior to infusion
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to infusion
☐ Other: ______________________

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):
Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)
Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: ______________________ NPI Number: __________
Office Phone: ______________ Office Fax: ______________
Prescriber Signature: ______________________ Date: __________