Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
	New referral	Order change	Order Renewal
Patient preferred clinic:			

Tysabri® (natalizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies:	See list / NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

	G35 - Relapsing Multiple Sclerosis		K50.9_____ - Crohn's Disease
	K50.8_____ - Crohn's Disease (small & large intestine)		K50.0_____ - Crohn's Disease (small intestine)
	K50.1_____ - Crohn's Disease (large intestine)		
	_____- Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Anti-JCV antibodies as required by payor or REMS program

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive natalizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of therapy.

IV

Diphenhydramine	☐ 25mg	☐ 50mg		
Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:	
Famotidine	☐ 20mg	☐ 40 mg		
Other:	☐			

PO

Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg	
Famotidine	☐ 20mg	☐ 40mg			
Diphenhydramine	☐ 25mg	☐ 50mg			
Fexofenadine	☐ 60mg	☐ 180mg			
Cetirizine	☐ 10mg				
Loratadine	☐ 10mg				
Other:	☐				

MEDICATION:

☑ Tysabri® (natalizumab) 300 mg in 100 ml NS IV to infuse over at least 1- hour.

Follow first 12 infusions with a one hour post infusion observation.

LAB ORDERS:

☐ Draw JCV antibody test every 6 months

☐ Draw JCV antibody test every _____

FREQUENCY:

☐ Dosing every 4 weeks, no less than every 28 days.

☐ Other: _____

SPECIAL/OTHER LAB ORDERS:

☐ _____

_____

***Prior to each infusion: ensure that the patient has a current Notice of Patient Authorization on file to receive Tysabri® (natalizumab) for their diagnosis and complete/submit Pre-infusion Patient Checklist within 24 hours to Biogen Idec**

Prescriber to monitor patient for symptoms of PML as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	