Natalizumab (Tysabri)

Provider Order Form rev. 08/06/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Multiple Sclerosis: ☐ RRMS ☐ PPMS ☐ SPMS

Crohn's Disease: Other: Description:

REQUIRED INFORMATION

☑ JCV results _____ Date: _____

THERAPY ADMINISTRATION & DOSING

☑ Administer Tysabri 300 mg in 100 ml 0.9% sodium chloride intravenously over 60 minutes. Flush IV line and tubing with 10ml 0.9% NS after infusion

☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion. After 12 infusions without an infusion reaction, use clinical judgement and determine if observation period is still needed.

FREQUENCY *(Choose One)*

☐ Every 4 weeks

☐ Other: _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____

☐ LFT ☐ at each dose ☐ every: _____

☐ JCV Antibody ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Prior to every appointment:

- Confirm patient is authorized in TOUCH Prescribing Program
- Provide and review patient with Tysabri Patient Medication Guide
- Complete Pre-Infusion Patient Checklist

☑ Hold infusion and notify provider if patient reports fever or signs/symptoms of illness/active infection, or signs of thrombocytopenia.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI, documentation of TOUCH enrollment

Required Labs: CRP, ESR, JCV, TB, Hep B

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.