Natalizumab (Tysabri, Tyruko)

Novella Infusion

Provider Order Form rev. 6/29/2026

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)*

G35.A Relapsing-Remitting MS	G35.B0 Primary Progressive MS, Unspecified	G35.B1 Active Primary Progressive MS
G35.B2 Non-Active Primary Progressive MS	G35.C0 Secondary Progressive MS, Unspecified	G35.D MS, Unspecified
G35.C1 Active Secondary Progresive MS	G35.C2 Non-Active Secondary Progressive MS	Other:

Crohn's Disease: Description:

REQUIRED INFORMATION

☑ JCV results __________Date: ___________

THERAPY ADMINISTRATION & DOSING

☐ Administer Natalizumab or Natalizumab biosimilar.

☐ Administer this specific Natalizumab product: _________________

☑ Administer Natalizumab 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 REMS Prescribing Program
- Provide and review patient with 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: JCV

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.