

MRN: _____



Standard Natalizumab Plan of Treatment

(Re)Certification Period From _____ to _____

Note: We may require MD office notes and/or a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ **Height** _____ **Weight:** _____

Allergies: _____

Primary Diagnosis: Relapsing Multiple Sclerosis

Secondary Diagnosis: _____

This section must be completed by the referring physician.

Patient has been on the following medication(s) for treatment of MS: _____.

These medications will be discontinued as of _____.

Patient may receive Natalizumab after wash-out period of _____ weeks or _____ months.

ORDERS:

Obtain weight each visit. Vital Signs : baseline then every 15 mins until infusion complete and 1 hr post infusion for the first 3 infusions, after 3rd infusion- baseline then every 30 mins until infusion is complete and 1 hr post infusion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Pump, tubing, and supplies needed to complete prescribed therapy.

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.

Normal Saline Flush 3-10 ml pre- infusion, after primary drug has infused, Infuse Normal Saline 0.9% 20-50 ml to flush tubing/line followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.

If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Premedicate None **OR**

30 minutes prior to infusion with 650 mg Acetaminophen PO and one of the following *oral* antihistamines:

Diphenhydramine 50mg Fexofenadine 60mg Fexofenadine 180mg Cetirizine 10mg Loratadine 10 mg

OR Premedicate with other _____

Drug:

Natalizumab 300mg in 100ml NS IV over 1 hour Every 4 weeks, Monitor pt. for 1 hour post infusion

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physician's Signature: _____ / _____ Date: _____

(Dispense as written)

(Substitution permitted)

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:

TOLL FREE FAX: (866) 872-8920