Palmetto Infusion Services
COMPLIANCE

Phone: 800-809-1265

MRN:_____
DOB:_____

Standard Tysabri Plan of Treatment

(Re)Certification Period From_____to_____

NOTE: Patient ***may be ineligible*** to receive Tysabri if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient's Name _____Height_____ Weight: _____
Allergies:_____

Primary Diagnosis: **ICD-10 G35 Relapsing Multiple Sclerosis**

This section must be completed by the referring physician.

Patient has been on the following medication(s) for treatment of MS (Must have failed 2 or more MS medications):
_____.

These medications will be discontinued as of _____.

Patient may receive Tysabri 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 before and after infusion, followed by Heparin 100 units/ml 1 – 5 ml 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 ☐ Cetirizine10mg ☐ Loratadine 10 mg

OR Premedicate with other _____

Drug:

Tysabri 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)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:

866-872-8920

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