Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265

Standard Tysabri 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 ☐ 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