Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Tysabri® (natalizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	G35 - Relapsing Multiple Sclerosis	☐	K50.9_____ - Crohn's Disease
☐	K50.8_____ - Crohn's Disease (small & large intestine)	☐	K50.0_____ - Crohn's Disease (small intestine)
☐	K50.1_____ - Crohn's Disease (large intestine)		
☐	_____ - Other:_____		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Anti-JCV antibodies as required by payor or REMS program		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive natalizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of therapy.

IV	Diphenhydramine	◯ 25mg	◯ 50mg				
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:			
	Famotidine	◯ 20mg	◯ 40 mg				
	Other:	◯					

PO	Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg	◯ 1000mg
	Famotidine	◯ 20mg	◯ 40mg		
	Diphenhydramine	◯ 25mg	◯ 50mg		
	Fexofenadine	◯ 60mg	◯ 180mg		
	Cetirizine	◯ 10mg			
	Loratadine	◯ 10mg			
	Other:	◯			

MEDICATION:

☑ Tysabri® (natalizumab) 300 mg per 100 ml NS IV to infuse over at least 1- hour.

Follow first 12 infusions with a one hour post infusion observation.

FREQUENCY:

◯ Dosing every 4 weeks, no less than every 28 days.

◯ Other: _____

LAB ORDERS:

Draw JCV antibody test every 6 months

SPECIAL/OTHER LAB ORDERS:

◯ _____

_____

***Prior to each infusion: ensure that the patient has a current Notice of Patient Authorization on file to receive Tysabri® (natalizumab) for their diagnosis and complete/submit Pre-infusion Patient Checklist within 24 hours to Biogen Idec**

Prescriber to monitor patient for symptoms of PML as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	