Natalizumab (Tysabri)

Provider Order Form *rev. 06/25/2024*

IVCARE INFUSION

710 Nashville Pike, Suite 103
Gallatin. TN. 37066
P: (615) 471-8673
F: (615) 471-8674
www.ivcareinfusion.com
Email : info@ivcareinfusion.com

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Verify patient is enrolled and authorized in TOUCH program. Complete pre-infusion checklist at www.touchprogram.com; notify provider of any contraindications to infusion.

☑ Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post- procedure observation.

LABORATORY ORDERS

☐ STRATIFY JCV Antibody ELISA with reflex to inhibition assay, JCV with index
☐ at each dose ☐ every _____

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION ORDERS

(ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☑ **Natalizumab** (Tysabri) in 100ml 0.9% sodium chloride, intravenous infusion
- Dose: ☑ 300mg
- Frequency: ☐ every 4 weeks / ☐ other: _____
- Infuse over 60 minutes

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient required to stay for 1-hour observation post infusion

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Email: info@ivcareinfusion.com or fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to:

FAX NUMBER FOR TYSABRI REFERRALS: (615) 471-8674