

Tysabri (Natalizumab) Infusion Orders

Patient Name: _____ DOB: _____ Male Female
Diagnosis (please provide ICD10 code) _____
 NKDA Allergies: _____
 New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

PREMEDICATION

- Acetaminophen 1000mg PO Solu-Medrol 125mg IVP Solu-
 Diphenhydramine 25mg PO Cortef 100mg IVP
 Ceterizine 10mg PO Diphenhydramine 25mg IVP

TYSABRI ORDERS

DOSING:

- 300mg in 100ml 0.9% sodium chloride, intravenous infusion, administered over 60 minutes

FREQUENCY:

- Every 4 weeks (28 days)

Other: _____

Sage Infusion Standing Orders:

- Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

REQUIRED DOCUMENTS

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)
 Most Recent Labs including anti-JCV antibodies
 Tysabri TOUCH Authorization Form
 Previous MS Drug Therapy History, including therapies trailed and or failed

REFILLS:

- _____
(if not indicated prescription will expire one year from date signed)

Date