Tysabri (Natalizumab)

Preferred Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
P: (855) 481-8375
F: (512) 233-2288

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:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
  - Patient has relapsing-remitting multiple sclerosis
  - Patient has moderately to severely active Crohn's disease who had an inadequate response to, or was unable to tolerate, conventional CD therapies and inhibitors to TNF
  -JCV results

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.
☑ Verify patient has not received IVIG infusion within the previous 6 months. If so, contact prescriber to determine if infusion should be given.
☑ Verify patient is not pregnant (if appropriate)

PRE-MEDICATION
(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: _____

LABORATORY

☐ 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: _____

THERAPY

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

☐ Flush with 0.9% sodium chloride at infusion completion

☑ Patient is 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)

Provider Name (Print): Provider Signature: Date:

Harbor Health