

Natalizumab (Tysabri®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Is this the first dose? Yes - Date of first dose: _____ No - Date of next dose: _____

Hepatitis B Status: Titer Date: _____ Positive Negative Prescriber declines based on patient assessment

TB Status PPD (negative) – date: _____ Active TB Unknown
 Last chest x-ray – date: _____ Other _____
 Past positive TB infection, course taken: _____

Natalizumab (Tysabri®) Prescription

Natalizumab (Tysabri®) 300 mg refill as directed x 1 year

Infuse 300 mg IV over 60 minutes every 4 weeks.

Provider to enroll patient in Tysabri Touch REMS program.

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

Pre-Medication Orders

Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

Loratadine 10 mg PO 30 min before infusion. Patient may decline.

Methylprednisolone 40 mg IV push 20 minutes prior to infusion.

Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders

No labs ordered at this time.

Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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