BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

TYSABRI (NATALIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Relapsing-remitting multiple sclerosis (G35.A)
☐ Primary progressive multiple sclerosis, active (G35.B1)
☐ Secondary progressive multiple sclerosis, unspecified (G35.C0)
☐ Secondary progressive multiple sclerosis, non-active (G35.C2)
☐ Primary progressive multiple sclerosis, unspecified (G35.B0)
☐ Primary progressive multiple sclerosis, non-active (G35.B2)
☐ Secondary progressive multiple sclerosis, active (G35.C1)
☐ Multiple sclerosis, unspecified (G35.D)

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Pregnancy Test (if applicable)
☐ Tried and Failed therapies
☐ H&P and Clinical/Progress notes supporting primary diagnosis
☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg & total HepB Core antibody
☐ Anti-JCV antibodies test result

If MS, current MS treatment and end of current therapy date: _____

Is your patient currently enrolled in the TOUCH (FDA REMS) program? ☐ Yes ☐ No

MEDICATION ORDERS

Dosing

☐ Tysabri 300 mg IV every 4 weeks
☐ Tysabri 300 mg IV every _____ weeks
☐ Patient has had 12 infusions without evidence of hypersensitivity and does not require post-infusion observation

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

**(if not indicated, order will expire 1 year from date signed)*

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATIONS ORDERS

☐ Acetaminophen 650mg PO prior to infusion
☐ Methylprednisolone _____mg Slow IV Push prior to infusion
☐ Diphenhydramine 25mg PO prior to infusion
☐ Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

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