LIFEBRIDGE HEALTH
CARE BRAVELY

NATALIZUMAB (Tysabri®) ORDER FORM

Patient Name: _____ DOB: _____

Allergies: _____ Height (cm) : _____ Weight (kg) : _____

Diagnosis: _____ Diagnosis Code: _____

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Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.

- ☐ Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- ☐ Demographics / insurance information attached, or available in Cerner.
- ☐ Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: _____
- ☐ Pre-appointment lab results (completed within 90 days): fax results of ***anti-JCV antibody*** with order form or indicate if available in Cerner (date): _____
- ☐ Notification of TOUCH Program authorization attached or indicate if available in Cerner (date): _____

NOTE: Baseline screening for latent infections (e.g., hepatitis, tuberculosis) is recommended. Patients should be monitored for symptoms of hepatotoxicity and periodically undergo radiographic assessment for signs of progressive multifocal leukoencephalopathy.

Treatment:

☐ ***Crohn's disease***

Natalizumab 300 mg in 100 mL NS IV over 1 hour every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

☐ ***Multiple sclerosis, relapsing***

Limited evidence suggests extended interval infusion (administration every 5 to 8 weeks) may be associated with lower risk of progressive multifocal leukoencephalopathy and similar efficacy

Natalizumab 300 mg in 100 mL NS IV over 1 hour every _____ weeks

Duration of therapy (1 year unless otherwise specified): _____

Protocol Orders:

☒ Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.

☒ Extravasation Management: Follow established protocol for extravasation as needed.

☒ Port Care and Flush per Nursing Protocol: Single-lumen flush protocol or double-lumen flush protocol as appropriate.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

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