PREMIER INFUSION CENTER

📜 Tysabri (natalizumab) IV Infusion Order Form

📞 405-442-7577 📠 405-442-7223
📧 orders@premierinfusioncenter.com

👤 Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

🔹 Diagnosis (ICD-10 Selection)

☐ G35 – Multiple sclerosis
☐ K50.90 – Crohn's disease, unspecified
☐ Other: _____ **ICD-10 Code:** _____

🔹 Infusion Order

☐ 300 mg IV in 100 mL 0.9% sodium chloride
☐ Infuse over 60 minutes using 0.2-micron in-line filter
☐ Frequency: Every 4 weeks
☐ Flush with 0.9% sodium chloride post-infusion
☐ Observation:
☐ 60 minutes post-infusion (first 12 doses)
☐ 15 minutes post-infusion (after 12 doses if no reaction)
☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

🔹 TOUCH Program Compliance

☐ Patient is enrolled in the TOUCH Prescribing Program
☐ Pre-infusion checklist completed prior to each dose
☐ JC Virus antibody status documented
☐ Provider acknowledges risk/benefit discussion for JCV-positive patients

🔹 Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

🔹 Adverse Reaction & Anaphylaxis Orders

☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
☐ Other – please fax preferred reaction orders to 405-442-7223

🔹 Premedication (Optional)

☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Famotidine: ☐ 20 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

🔹 Laboratory Monitoring

☐ CBC ☐ CMP ☐ Hepatic function panel
☐ JC Virus Antibody with Index
☐ Tysabri Antibody
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Each infusion ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

🔹 Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies or intolerance
☐ TOUCH enrollment confirmation

- **Ordering Provider & Demographics**

  - **Name:** _____
  - **NPI:** _____ **License #:** _____
  - **Contact:** _____ **Phone:** _____ **Fax:** _____
  - **Email:** _____
  - **Signature:** _____ **Date:** ____ / _____ / _____