

TYSABRI MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ **Diagnosis** Crohn's diagnosis codes require the complete ICD-10 code, with all possible digits after the decimal.

- ☐ G35 Multiple Sclerosis ☐ K50.1 Crohn's Disease (large int)
☐ K50.0 Crohn's Disease (small int) ☐ K50.8 Crohn's Disease (small & large int)

■ **Details Needed for Approval**

- The patient must be enrolled in the Touch Program. Please enter patient's enrollment number: _____
- Please provide a JCV test result from within 6 months. If positive, provide documentation of risk discussion with patient.
- For MS: Which type of MS does the patient have? Circle one: CIS RRMS PPMS SPMS
- For MS: For patients starting on Tysabri, please provide baseline tool measurements (ie. EDISS score, T25-FW, 9-HPT, etc.)
- For MS: Provide MRI reports documenting status of current lesions and changes from prior scans.
- For Crohn's: Please provide documentation of other biological and anti-TNF medication utilization and/or intolerance and all relevant medical history. For continuation of therapy, provide documentation of improvement from baseline.
- **FOR ALL DIAGNOSES:** Documentation of all medication utilization/failures/intolerances, and a list of all concurrent meds.

■ **Premedication Order**

Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:

- ☐ Acetaminophen _____mg ☐ Diphenhydramine _____mg ☐ Cetirizine 10mg

IV medications to be administered prior to start of the infusion treatment:

- ☐ Diphenhydramine _____mg ☐ Methylprednisolone _____mg ☐ _____

■ **Medication Order**

- ☐ Tysabri (natalizumab) 300mg by IV over 60 minutes every 28 days +/- 1 day for _____ months.

Allow diluted solution to warm to room temperature prior to infusion. Administered in 100ml of normal saline via peripheral IV. After the infusion is complete, flush with normal saline. In first year, observe the patient for one hour after the infusion is complete. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Diphenhydramine 50mg IV and Methylprednisolone 125mg IV for allergic reactions.
- Albuterol sulfate 2.5ml by nebulizer for wheezing and respiratory reactions. Provide oxygen as needed.
- Famotidine 20mg IVP for minor cutaneous reactions which do not respond to diphenhydramine.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

■ **Documentation to Include:**

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.