Natalizumab (Tysabri)

Provider Order Form rev. 10/4/2021

IVX HEALTH

PATIENT INFORMATION

Date:	Patient Name:		DOB:
ICD-10 code (required):		ICD-10 description:	
☐ NKDA Allergies:			Weight lbs/kg:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

NURSING

☑ Verify patient is enrolled and authorized in TOUCH program. Complete pre-infusion checklist at www.touchprogram.com; notify provider of any contraindications to infusion

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

LABORATORY ORDERS

☐ STRATIFY JCV Antibody ELISA with reflex to inhibition assay, JCV with index
☐ at each dose ☐ every _____

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION ORDERS

(ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☑ **Natalizumab** (Tysabri) in 100ml 0.9% sodium chloride, intravenous infusion
- Dose: ☑ 300mg
- Frequency: ☐ every 4 weeks / ☐ other: _____
- Infuse over 60 minutes
- Refills: ☐ Zero / ☐ for 12 months / ☐ Other: _____

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient required to stay for 1-hour observation post infusion

☐ Patient is NOT required to stay for observation time

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

☐ BAY AREA: 844-899-0275	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN: 888-615-1445
☐ CINCINNATI: 844-946-0868	☐ HARRISBURG: 844-859-4235	☐ KANSAS CITY: 844-900-1292	☐ TAMPA: 844-946-0849	☐ MIDDLE TN: 888-615-1445
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ ORLANDO: 844-946-0867	☐ WEST FLORIDA: 844-946-0849	☐ EAST TN: 888-615-1445