Natalizumab (Tysabri)

Provider Order Form *rev. 10/12/2022*

IVX HEALTH

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

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)

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: _____

SPECIAL INSTRUCTIONS

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: _____

THERAPY ADMINISTRATION

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

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient required to stay for 1-hour observation post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

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

FAX NUMBERS

☐ CONNECTICUT: 860-955-1532	☐ HARRISBURG: 844-859-4235	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN/AR: 888-615-1445
☐ BAY AREA: 844-889-0275	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ RALEIGH: 919-287-2551	☐ MIDDLE TN: 888-615-1445
☐ CHARLOTTE: 336-663-0143	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144	