Natalizumab (Tysabri/Tyruko)

Fax to 505-420-4848 or Email to refer@optimuminfusion.com

Optimum INFUSION

PATIENT INFORMATION

Referral Status: ◯ New Referral ◯ Updated Order ◯ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ☐ G35.A: RRMS ☐ G35.B0: PPMS, Unspecified ☐ G35.B1: PPMS, Active ☐ G35.B2: PPMS, Non-Active ☐ Other

☐ G35.C0: SPMS, Unspecified ☐ G35.C1: SPMS, Active ☐ G35.C2: SPMS, Non-Active ☐ G35.D: MS, Unspecified

☐ 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 and provider (if applicable) are enrolled and authorized in REMS program. Complete a pre-infusion checklist on REMS site; notify provider of any contraindications to infusion

☑ Provide nursing care per Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation

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

☐ JCV (Quest STRATIFY JCV Antibody with Index with Reflex to Inhibition 91665; LabCorp Anti-JCV Antibody Index 164142)
☐ at each dose ☐ every _____
☐ CBC ☐ at each dose ☐ every _____ _____
☐ CMP ☐ at each dose ☐ every _____ _____
☐ Other: _____ _____

THERAPY ADMINISTRATION

Natalizumab (Tysabri) OR natalizumab biosimilar as required by patient's insurance

NOTE: (Natalizumab products include: Tysabri or Tyruko)

☐ 100 mL 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
☑ Observe patient for one hour after the infusion is complete for the first twelve infusions.
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

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

SUBMIT ORDER FORM TO OPTIMUM INFUSION:
☐ **FAX:** 505-420-4848
☐ **EMAIL:** refer@optimuminfusion.com

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