McLeod Health

Place Sticker Here

Natalizumab (Tysabri) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

□ G35 Relapsing Remitting Multiple Sclerosis

□ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

□ None

□ Acetaminophen 650 mg PO

□ Diphenhydramine: Dose: □ 25 mg □ 50 mg Route: □ PO or □ IVP

□ Methylprednisolone: Dose: □ 40 mg or □ 125 mg Route: IVP

□ Famotidine: Dose: 20 mg Route: □ PO or □ IVPB

□ Other (include drug, dose, and route): _____

Drug Orders:

- Natalizumab (Tysabri) (J2323) 300 mg per 100 mL Sodium Chloride 0.9% IV to infuse over 1 hour once every 4 weeks
- Order Duration: Six months unless otherwise specified (Other: _____)

Standing Orders:

- Monitor patient for 1 hour following completion of infusion.
- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

● Ensure prescriber is enrolled in the MS Touch Prescribing Program and that the patient has current Notice of Patient Authorization on file. Send copy with completed treatment plan to Infusion Services. Infusion Services will complete and submit the pre-infusion patient checklist prior to each treatment.

● Provide anti-JCV antibody results prior to start of therapy and within the last 6 months

Previous Therapies:

● For new patient referrals, please send history and physical and most recent physician note with completed plan

● If patient has previously received natalizumab at another facility, please provide last date received: _____

● If patient has previously received another biologic therapy, please provide the name: _____ and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)