

Natalizumab (Tysabri)

Provider Order Form rev. 09/23/2025

PATIENT INFORMATION

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

Patient Name:	DOB:	Patient Phone:
Patient Address:	Patient Email:	
Allergies:	☐ NKDA	Weight (lbs/kg): Height (in/cm):
Sex: ☐ M / ☐ F	Date of Last Infusion:	Next Due Date: Preferred Location:

DIAGNOSIS (Please provide ICD-10 code in space provided)

G35.A Relapsing-Remitting MS	G35.B0 Primary Progressive MS, Unspecified	G35.B1 Active Primary Progressive MS
G35.B2 Non-Active Primary Progressive MS	G35.C0 Secondary Progressive MS, Unspecified	G35.D MS, Unspecified
G35.C1 Active Secondary Progressive MS	G35.C2 Non-Active Secondary Progressive MS	Other:
Crohn's Disease:	Description:	

REQUIRED INFORMATION

☒ JCV results _____ Date: _____

THERAPY ADMINISTRATION & DOSING

- ☒ Administer Tysabri 300 mg in 100 ml 0.9% sodium chloride intravenously over 60 minutes.
- ☒ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion. After 12 infusions without an infusion reaction, use clinical judgement and determine if observation period is still needed.

FREQUENCY (Choose One)

- ☐ Every 4 weeks
- ☐ Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

- ☐ Tylenol ☐ 500mg / ☐ 650mg PO
- ☐ Loratadine 10mg PO
- ☐ Pepcid 20mg ☐ PO / ☐ IVP
- ☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
- ☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
- ☐ Other: _____

NURSING

- ☒ Prior to every appointment:
- Confirm patient is authorized in TOUCH Prescribing Program
 - Provide and review patient with Tysabri Patient Medication Guide
 - Complete Pre-Infusion Patient Checklist
- ☒ Hold infusion and notify provider if patient reports fever or signs/symptoms of illness/active infection, or signs of thrombocytopenia.
- ☒ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name:	Preferred Contact Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, MRI, documentation of TOUCH enrollment

Required Labs: JCV, TB, Hep B

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.