Natalizumab (Tysabri, Tyruko)

Provider Order Form rev. 06/29/2026

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 Progresive MS ☐ G35.C2 Non-Active Secondary Progressive MS ☐ Other:

☐ Crohn's Disease: Description:

REQUIRED INFORMATION

☑ JCV results _____ Date: _____

THERAPY ADMINISTRATION & DOSING

☐ Administer Natalizumab or Natalizumab biosimilar.
☐ Administer this specific Natalizumab product: _____

☑ Administer Natalizumab 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 REMS Prescribing Program
- Provide and review patient with 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.