



Oregon Health & Science University  
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER  
**Natalizumab (TYSABRI) Infusion**

Page 1 of 3

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

Patient Identification

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.**

Weight: \_\_\_\_\_ kg      Height: \_\_\_\_\_ cm

Allergies: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_ Patient to follow up with provider on date: \_\_\_\_\_

**\*\*This plan will expire after 365 days at which time a new order will need to be placed\*\***

**GUIDELINES FOR ORDERING**

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Natalizumab is restricted to credentialed prescribers only through the TOUCH™ Prescribing Program
  - a. Prescribers **MUST** be enrolled in the TOUCH™ Prescribing Program
  - b. Patients **MUST** be enrolled in the TOUCH™ Prescribing Program
  - c. Contact the TOUCH™ Prescribing Program at 1-800-456-2255 for details and enrollment
  - d. Notify Biogen Customer Service of any adverse reactions at 1-800-456-2255

**LABS:**

**During first year of treatment:**

- Complete Metabolic Panel, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- Complete Metabolic Panel, Routine, ONCE, every 3 months (after first year of treatment)
- CBC with differential, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- CBC with differential, Routine, ONCE, every 6 months (after first year of treatment)
- HCG Qual, URINE, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- Stratify JC Virus Antibody with Reflex to Inhibition Assay, SERUM, Routine, ONCE, every visit

**After first year of treatment:**

- Complete Metabolic Panel , Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- Complete Metabolic Panel , Routine, ONCE, every 3 months (after first year of treatment)
- CBC with differential, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- CBC with differential, Routine, ONCE, every 6 months (after first year of treatment)
- HCG Qual, URINE, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – *Circle One*
- Stratify JC Virus Antibody with Reflex to Inhibition Assay, SERUM, Routine, ONCE, every visit

**NURSING ORDERS:**

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes.
2. VITAL SIGNS – Obtain vital signs before start of Natalizumab infusion and at end of infusion.
3. Do not need lab results of CBC + Diff and/or CMP to start Natalizumab infusion. If HCG urine test is ordered, please verify that the urine test is negative before starting the Natalizumab infusion.
4. Review “Medication Guide” with patient. Review and complete TOUCH™ on-line checklist with patient. Proceed according to guidelines.
5. Patient’s TOUCH™ Prescribing Biogen Authorization # is: \_\_\_\_\_



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6. Encourage patient to continue follow-up with physician every 3 months.
7. Observe patient for infusion related reaction during and for 1 hour post infusion. For patients who have received 12 infusions without a hypersensitivity reaction, post infusion observation is not necessary. Discharge when stable.
8. Assess patient for signs of infection - notify provider if present.
9. Draw the STRATIFY JC VIRUS ANTIBODY W/ REFLEX TO INHIBITION ASSAY, SERUM lab before every Tysabri infusion. Result is not needed to proceed with treatment. Check most recently drawn titer to make sure it is negative prior to proceeding with treatment. Hold treatment and contact patient's neurology provider if positive or if the JC virus was not drawn at last month's visit.
10. HYPERSENSITIVITY/INFUSION REACTION – If infusion reaction occurs:
  - a. STOP INFUSION
  - b. Infuse normal saline at 100 to 200 mL/hr when Natalizumab is stopped for emergency or PRN medication
  - c. DO NOT RESUME INFUSION. Notify provider and Biogen Customer Service (1-800-456-2255) of adverse reaction. Discontinue all future Natalizumab infusions.

**PRE-MEDICATIONS:**

- sodium chloride 0.9% solution, 250 mL, intravenous, Infuse at rate necessary to keep vein open (KVO) until natalizumab is started and for 1 hour after infusion is complete, then discontinue.

**MEDICATIONS:**

- natalizumab (TYSABRI), 300 mg, intravenous, in sodium chloride 0.9% 100 mL, ONCE, over 60 minutes

**Interval: (must check one)**

- Once
- Every 4 weeks x \_\_\_\_ doses
- Every 4 weeks until discontinued

**HYPERSENSITIVITY MEDICATIONS:**

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction



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**By signing below, I represent the following:**

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in:  Oregon  \_\_\_\_\_ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

**My physician license Number is # \_\_\_\_\_ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION);** and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

**Provider signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

**Please check the appropriate box for the patient's preferred clinic location:**

- Beaverton**  
OHSU Knight Cancer Institute  
15700 SW Greystone Court  
Beaverton, OR 97006  
Phone number: 971-262-9000  
Fax number: 503-346-8058
- NW Portland**  
Legacy Good Samaritan campus  
Medical Office Building 3, Suite 150  
1130 NW 22nd Ave  
Portland, OR 97210  
Phone number: 971-262-9600  
Fax number: 503-346-8058
- Gresham**  
Legacy Mount Hood campus  
Medical Office Building 3, Suite 140  
24988 SE Stark  
Gresham, OR 97030  
Phone number: 971-262-9500  
Fax number: 503-346-8058
- Tualatin**  
Legacy Meridian Park campus  
Medical Office Building 2, Suite 140  
19260 SW 65th Ave  
Tualatin, OR 97062  
Phone number: 971-262-9700  
Fax number: 503-346-8058

Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)