ADULT AMBULATORY INFUSION ORDER
Natalizumab (TYSABRI) Infusion

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, declotting (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.
5. Patient’s TOUCH™ Prescribing Biogen Authorization # is: _______________________
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 (Policy 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 x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
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: ___________

OLC Central Intake Nurse:
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.ohsuKnights.com/infusionorders