Checklist for Tysabri (natalizumab) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____ **NPI:** _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ☐ Patient demographic information
- ☐ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ☐ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Tysabri
  - Medication list and allergies
- ☐ Supporting lab reports/imaging for Tysabri treatment
  - Baseline: MRI Brain, JCV antibody, CBC w diff, CMP, Varicella antibody
  - *Recommended for continued therapy*: frequent MRI Brain, JCV, CBC w diff, and CMP monitoring
- ☐ Prescriber must be registered in the TOUCH® Prescribing Program to prescribe Tysabri
  - Provider must authorize continued treatment every 6 months
- ☐ Tysabri Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

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Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterNE.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Tysabri (natalizumab)

Date of Order: _____ ☐ New Start ☐ Maintenance
Date of last infusion: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s):_____

☐ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

☐ Acetaminophen 1000mg PO
☐ Loratadine 10mg or Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Diphenhydramine 25mg IV
☐ Solu-medrol 125mg IV
☐ Other: _____

Lab Orders:

☐ JCV antibody every _____ months
☐ CBC w diff, CMP every _____ months

Tysabri Medication Order

☐ Tysabri 300mg in 100ml NS IV over 1 hour every 4 weeks x 12 months
☐ Tysabri 300mg in 100ml NS IV over 1 hour every ___weeks x 12 months
✓ Monitor patient for 1 hour after Tysabri infusion for first 12 treatments, then monitor per ICNE protocol. Infuse normal saline 100ml/hr during monitoring period.

Administration:

- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ Do not administer if any suspected signs/symptoms of PML.
- ✓ Complete required TOUCH screening and checklist prior to each infusion.
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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