

477 W. Horton Rd Bellingham, WA 98226 Phone (360) 933-4892 Fax (360) 933-1197

Patient Name:		
Date of Birth:	Wt:	Ht:
IV Access:		
Allergies:		

Tysabri Order Form

Please complete this form and fax to (360)933-1197. Call our office for pharmacist recommendations.

<u>Diagnoses:</u>	☐ Multiple Sclerosis	ICD	-10: G35		
	☐ Crohn's disease	ICD-10:			
	☐ Other:		-10:		
Has patient re	ceived Tysabri before? ☐ No ☐ Yes	(date of last infusion:)		
Medication Orders:					
◆ Tysabri (natalizumab) ☐ 300 mg/100 ml NS IV over 1 hour every 4 weeks					
↓ Tyour	Other dose/instructions:				
A.I I					
 Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion. Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol. Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio). Infusion Reaction Management per Infusion Solutions protocol as needed. 					
Nursing Ord	lers:				
 If no central IV access, RN to insert peripheral IV. Monitor for infusion reactions during infusions. Observe for at least 1 hour after completion for the first 12 infusions; subsequent monitoring period to be determined by clinical judgment if no hypersensitivity reaction has been observed. Other: 					
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□ T c □ JC □ Tys □ TSI □ Vita □ Oth	IP patic function panel ell subsets (Lymphocyte panel) Virus Antibody with Index sabri Antibody	□Each infusion	□Other frequency		
Prescriber Please Prin		□ Check box to initiate	Date		