



ADULT AMBULATORY INFUSION ORDER
3/2023
NATALIZUMAB (TYSABRI) Infusion

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Treatment Start Date: _____

**** If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.****

GUIDELINES FOR ORDERING:

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.
- 3) Send a copy of related lab results if not available for review in Epic.
- 4) 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.

Recommended LABS:

- JCV. Date of last result: _____. Include a copy of results if not available in Epic.

Optional LABS: (to be done at infusion appointments)

- CBC with differential, Routine, every _____.
- Hepatic Function Panel, Routine, every _____.
- Other: _____

Optional PRE-MEDICATIONS: (To be administered 30 minutes prior to infusion)

- DiphenhydrAMINE (BENADRYL) injection, 25 mg, iv.
- OR**
- DiphenhydrAMINE (BENADRYL) tablet, 25 mg, oral.
- Other: medication: _____ dose: _____ route: _____.

MEDICATION:

- ✓ **Natalizumab (TYSABRI)** 300 mg in sodium chloride 0.9% 100 mL, IV. Administer over 1 hour. Flush with NS before and after giving. Doses 1-12: Observe patients during the infusion and for one hour after the infusion is complete. Doses 13 and subsequent: One hour observation post-infusion is optional if patient is not having any symptoms after the infusion.

FREQUENCY: (must select one)

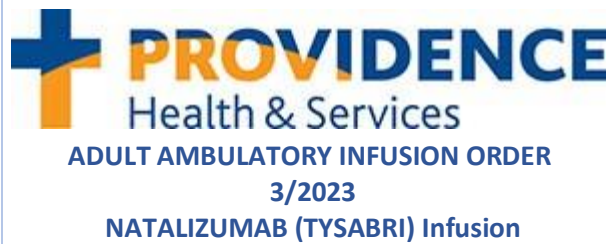
- Give every 4 weeks, at least 25 days apart.
- Give every _____ weeks.

AS NEEDED MEDICATIONS:

- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.

Standard included Nursing Orders:

- ✓ Ensure the patient is authorized with Touch Program to receive Tysabri before releasing dose each visit.
- ✓ OK to administer IV steroid treatment within 30 days prior to initial natalizumab dose. Verify that pulsed steroid order has been discontinued.
- ✓ Vital signs: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
- ✓ Insert peripheral IV if no iv access.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.



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- ✓ If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately. Include hypersensitivity reaction order set. (See attached form).

HYPERSENSITIVITY INFUSION REACTION ORDERS

STOP infusion if:

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.

1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

MEDICATIONS:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction. Starting when released.
- Diphenhydramine (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. Starting when released, For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. Starting when released, For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis, starting when released. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction p. Starting when released, For 1 dose. Shake well. Use with spacer.
- Start oxygen. For *MODERATE* Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For *SEVERE* Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.



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- EPINEPHrine 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis. Starting when released, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Starting when released. Run wide open to gravity.

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.

My physician license Number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Outpatient Infusion Services Intake Team:

Please check the appropriate box for the patient's preferred infusion center location:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone-541-387-6445 Call for fax # |
| <input type="checkbox"/> SEASIDE | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |