Fax your completed order to 877-734-1157

Patient Name: ________________________DOB: ____/___/________Date of Last Infusion: ______/___/_________
Height___________Weight__________
Infusion Location: (state and site) _____________________________________

Tysabri® (natalizumab) Infusion Orders

Diagnosis (add ICD-10 code and Classification)

__________Multiple Sclerosis	❑ RRMS	❑ PPMS	❑ PSMS
JCV results_____________Date_____________	❑ TOUCH Enrolled		

Nursing Orders:

- Prior to every appointment:
  - Confirm patient is authorized in TOUCH Prescribing Program
  - Provide and review patient with Tysabri Patient Medication Guide
  - Complete Pre-Infusion Patient Checklist
  - Hold infusion and notify provider if patient reports fever or signs/symptoms of illness/active infection, or signs of thrombocytopenia
- If infusion-related reaction occurs, stop infusion, and initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Labs: (frequency____)

❑ CBC w/diff	❑ LFT panel	❑ JCV™ Antibody	❑ Other:
Administer Tysabri 300 mg in 100 ml 0.9% sodium chloride intravenously over 60 minutes			
Frequency: ❑ Every 4 weeks ❑ Other: ____			

Observation Period:

- Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion
- Record vital signs prior to discharge

Additional Orders:

Provider Name (print):_____________________________________Date:____________________________

Provider Signature: _______________________________________Time: _____________________________

Reviewed 3/9/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.