Oregon Health & Science University **Hospital and Clinics Provider's Orders** PO9031 ADULT AMBULATORY INFUSION ORDER **Natalizumab (TYSABRI) Infusion** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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.
4. Review "Medication Guide" with patient. Review and complete TOUCH™ on-line checklist with patient. Proceed according to guidelines.
5. Patient's TOUCH™ Prescribing Biogen Authorization # is: _____

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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 (OHSU 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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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:** _____

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

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610