Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Natalizumab (TYSABRI) Infusion

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:

- ☐ Basic Metabolic Set, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Basic Metabolic Set, 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*

After first year of treatment:

- ☐ Basic Metabolic Set, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Basic Metabolic Set, 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*

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

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NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Please indicate patient's TOUCH™ Prescribing Program authorization number from Biogen. Authorization # is: _____
3. Review "Medication Guide" with patient. Review and complete TOUCH™ on-line checklist with patient. Proceed according to guidelines. **Note**: If patient answers "Yes" to any of the questions 1 through 3 in Step 3 of the checklist, **DO NOT** infuse natalizumab. Contact physician to obtain further orders regarding infusion.
4. Assess patient for signs of infection and notify prescriber if present.
5. If HCG urine test is ordered, please verify that urine HCG test is negative before starting natalizumab infusion.
6. Do not have to wait for results of CBC with differential and/or BMP before starting natalizumab infusion.
7. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, at end of infusion, 1 hour after infusion prior to discharge, and as clinically indicated.
8. Encourage patient to follow-up with the prescriber every 3 months.

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, Tuality 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 x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

AS NEEDED MEDICATIONS:

1. albuterol (PROVENTIL, VENTOLIN) 90 mcg/actuation inhaler, 2-4 puffs, every 10 Minutes AS NEEDED for bronchospasm
2. sodium chloride 0.9%, 1000 mL, intravenous, AS NEEDED, Infuse at 100-200 mL/hour, when natalizumab infusion is stopped for 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:

☐ TUALITY HEALTHCARE
An OHSU Partner

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

☐ MCMC
MID-COLUMBIA MEDICAL CENTER
A Planetree Patient-Centered Hospital

Celilo Cancer Center
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The Dalles, OR 97058
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