

ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):

Yakima Outpatient Infusion Care
808 N 39th Ave Yakima WA 98902
Phone: 509-575-1174
Fax: 509-577-5021

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

CODE STATUS

Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

NATALIZUMAB (Tysabri)

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE (REQUIRED):

- Multiple Sclerosis (ICD-10: _____)
- Crohn's Disease (ICD-10: _____)
- Other: _____ (ICD-10: _____)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation confirming patient is currently registered with the Tysabri Touch (REMS) program.

If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

BASELINE LAB REQUIREMENTS:

- ✓ Hepatitis B status (Vaccinated; HepBsAg _____ HepBsAb _____ HepB Core Ab _____)
- ✓ Negative TB Results (Date _____) | PPD | QuantiFERON Gold | Chest X-Ray | Other: _____

ROUTINE LABS (circle): CMP | CBC w/ diff | LFT | CRP | ESR | Other: _____

ROUTINE LABS FREQUENCY: Each Infusion (default) | Other: _____

IV ACCESS: Access and/or maintain IV or Port-A-Cath per appropriate facility protocol

TREATMENT REGIMEN: (another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)

NATALIZUMAB (Tysabri) IV Infusion

- 300 mg IV over 1 hour every 4 weeks *FDA-approved dosing*
- 300 mg IV over 1 hour every _____ weeks *additional information may be required to support non-FDA approved dosing*

ADDITIONAL INFORMATION: _____

MONITORING: 1st infusion: vital signs at baseline, at completion of infusion, and before discharge.

Subsequent infusions: vital signs at baseline and completion of infusion

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 60 minutes after infusion when vital signs are stable, and no reaction is present. If no infusion-related events with previous 6 infusions, may waive post infusion monitoring and discharge patient home at completion of infusion.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

NEW REFERRAL UPDATED REFERRAL

****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

NATALIZUMAB (Tysabri)

MultiCare 

Yakima Memorial Hospital