Ascension Rx

Natalizumab (Tysabri & Biosimilars) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ Anti-JCV Antibody
    - ☑ CMP
    - ☑ CBC with Differential
    - ☐ TB screening (QuantiFERON or alternative)
  - ☑ Maintenance (every _____)
    - ☑ Anti-JCV Antibody
    - ☑ CBC with Differential
    - ☑ CMP
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Live vaccines should not be given concurrently.

Nursing Order

- ☑ Due to risk of PML, confirm the patient and infusion center are enrolled and authorized in the REMS Prescribing Program prior to administration.
- ☑ Complete checklist prior to each dose of natalizumab. Notify the provider of any “Yes” responses that include any new or worsening symptoms before medication administration.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Dexamethasone 20 mg IV once

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- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

Medication Orders

Standard Dose

- ☑ Natalizumab 300 mg IV over approximately 1 hour every 4 weeks

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Monitor patient for 60 minutes after the infusion for the first year. If no evidence of hypersensitivity reaction is observed after the first 12 infusions, a 1-hour postinfusion observation period is no longer required and is according to clinical judgment.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

7/17/2026

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All orders are valid for 1 year from the ordered date unless otherwise indicated