Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Tysabri Infusion Order (Revised 4/3/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: Verify JCV antibody test completed within the past 6 months (If outside of Atrium, fax with order. Required prior to scheduling).

Infusion Therapy:

☒ Tysabri (natalizumab) 300 mg IV over 60 minutes

Frequency: every _____ weeks **ICD 10 code: _____**

Pre-Meds:

Administer 30 minutes prior to Tysabri

☒ Acetaminophen **500** mg PO x 1 **prior to initial 3 infusions**

☒ Benadryl **25** mg PO x 1 **prior to initial 3 infusions**

- May substitute Loratadine 10mg PO or Cetirizine 10mg PO per patient/provider preference

☐ SoluMedrol **250** mg IV x 1 **prior to initial 3 infusions**

PRN Medications:

☒ Zofran 8mg ODT PRN nausea/vomiting x 1

☒ Acetaminophen 500mg PO x 1 PRN headache, pre-infusion per patient request

☒ Benadryl 25mg PO PRN pre-infusion per patient request

Additional Orders:

_____

Special Instructions:

- Complete TOUCH pre-infusion checklist
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Patient may receive Tysabri without phone call to MS physician if sinus infection, upper respiratory infection, or urinary tract infection that has improved. They have been cleared by surgeon following surgery and no evidence of infection.
- Patient may not receive Tysabri if they present with neurological symptoms; have a fever >100°F or new GI dysfunction; the patient fulfills other exclusions from the TOUCH program; JCV test has not been completed within the last 6 months.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.
- Monitor patient for 60 minutes after infusion. Notify provider if patient declines to stay post-infusion.

Provider Name: _____

Provider Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN:

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