ARJ Infusion SERVICES

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Tysabri (Natalizumab) Order Form

Patient Information

Patient Name: _____ Date: _____

Physician: _____ Primary Diagnosis: _____

Allergies: _____ DOB: _____ Ht: _____ in / cm Wt : _____ lb / kg

Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other: _____ Lumen #: _____

Initiate the following orders: *ARJ policy and protocol to be provided upon request.*

Medication	Dose	Directions	Quantity/Refills
☒ Tysabri	300 mg/100 mL NS IV, every 4 weeks	☒ Infuse per manufacturer guidelines ☒ RN to monitor patient for 1 hour post infusion	Dispense: 1 month supply on all selected medications Refill x12 months unless otherwise noted ☐ *Other:* _____

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure.

☒ NS 50ml IV flush post infusion

Medications to be used as needed:

☐ Diphenhydramine 25-50 mg po every 4-6 hours as needed for chills, headache, rash/itching

☐ Acetaminophen 325-650 mg po every 4-6 hours as needed for fever, headache, or chills

☐ Other: _____

Adverse Reaction Orders: *Dispense 1 dose of each medication below.*

In the event of an infusion reaction *(ie: fever, chills, backache, headache)* the following orders will be followed and physician will be notified.

☒ **STOP Tysabri** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

☒ **Diphenhydramine**
50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated.

☒ **Acetaminophen**
325-650 mg (**OR** _____ mg) po at onset of symptoms.

☒ **Methylprednisolone**
125 mg (**OR** _____ mg) slow IV push over 5 minutes.

☒ **Epinephrine (1:1000)** by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used.

Additional Instructions

_____

_____

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.
ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

_____ Date: _____ | _____ Date: _____

Physician Signature Required - Substitution Permitted ***Physician Signature Required - Dispense as Written***