Natalizumab (TYSABRI)

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: ______________________________
DOB: ______________ Phone: ______________
Gender: ☐ Male ☐ Female
Allergies: ______________________________

DIAGNOSIS (ICD-10 code required):

☐ _______ Crohn's Disease
☐ _______ Multiple Sclerosis

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Natalizumab (TYSABRI) is only available through an FDA Risk Evaluation and Mitigation Strategies (REMS) Program, called the **TOUCH Prescribing Program**; prescribers must call 1-800-456-2255 for details/enrollment or enroll online at www.TOUCHprogram.com

Steps to Infusing Natalizumab (TYSABRI):

Step 1: **Confirm** that the patient is currently **authorized** to receive TYSABRI via TOUCH On-Line
Step 2: **Provide** the patient with the **Patient Medication Guide** and ensure he or she has read and understands it
Step 3: **Complete** the **Pre-infusion Patient Checklist** on TOUCH On-Line

NURSING CONSIDERATIONS:

- Do not prepare the infusion until the Pre-infusion Patient Checklist has been successfully completed
- If the patient answered YES to question 1, 2, or 3 in Step 3 of the Pre-infusion Patient Checklist, DO NOT INFUSE. Contact the healthcare provider who prescribed TYSABRI, review the patient's answers, and confirm authorization for infusion or hold as advised
- Submit the Pre-infusion Patient Checklist via TOUCH On-Line within 1 business day of the patient's visit and place a copy in the patient record
- The Pre-infusion Patient Checklist must be completed at every infusion visit, even if the patient is not infused

Premedications

☐ **No routine premeditations necessary.**
☐ ______________________________
☐ ______________________________

Medications

Patient Weight ______kg **(REQUIRED)**

☐ Infuse **Natalizumab (TYSABRI)** 300mg Intravenously over 60 minutes every 4 weeks, per the TOUCH Prescribing Program *Prescriber/Patient Enrollment Form.*

☐ Monitor for adverse reaction, including vital signs and pulse ox, every 30 minutes during infusion, and one hour post infusion.

☐ **IV LINE CARE** per Nursing Policy
☐ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

Special Instruction(s):

Provider Signature ______________ Date ______________ Email ______________
Printed Name ______________ Phone ______________ Fax ______________
Office Contact ______________ Phone ______________ Email ______________