PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

OUTPATIENT NATALIZUMAB (TYSABRI) ORDERS

Diagnosis: ☐ Multiple Sclerosis ☐ Crohn's Disease **ICD10:** _____

IV Access:

☐ Saline Lock:
- ☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
- ☑ Discontinue Saline Lock after therapy completed

☐ PICC Line:
- ☑ Routine PICC Line Care, labs and restoration
- ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

☑ **Prescriber/Patient Enrollment Form** (4 copies)

Done: Yes ☐ No ☐ Date: _____/_____/_____
Fax to appropriate Infusion Center (see header for fax numbers)

☑ Biogen Idec patient assign **enrollment number:** # _____

☑ Patient must have current notice of **patient authorization** in file for each visit

☑ Give patient a copy of "**Patient Medication Guide**" for each visit

☑ Confirm you have not received a **"Notice of Discontinuation"**

☑ Complete **pre-infusion checklist** on-line at ***www.touchprogram.com***, (whether infusion is given or not):

Multiple Sclerosis:
- If answers "No" to questions 1 - 4, administer Natalizumab (Tysabri) as ordered **OR**
- If answers "Yes" to any question 1 – 4, must contact prescriber for further orders. Prescriber clearance needed to proceed; Do not administer without a new order.

Crohn's Disease:
- If answers "No" to questions 1 – 3, administer Natalizumab (Tysabri) as ordered **OR**
- If answers "Yes" to any question, must contact prescriber for further orders. Prescriber clearance needed to proceed; Do not administer without a new order.

Medication:

☑ Natalizumab (Tysabri) *300 mg/100 mL 0.9% Sodium Chloride, IVPB, Infuse over one hour, then flush with 0.9% Sodium Chloride*

☐ Administer *ONCE:* Date: _____/_____/_____

OR

☐ Administer *ONCE, Every 4 weeks for 6 doses:*

Dose #1: Date: _____/_____/_____
Dose #2: Date: _____/_____/_____
Dose #3: Date: _____/_____/_____
Dose #4: Date: _____/_____/_____
Dose #5: Date: _____/_____/_____
Dose #6: Date: _____/_____/_____

Other: _____

_____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS