

# McLeod Health

## Natalizumab (Tysabri) Treatment Plan

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Allergies: \_\_\_\_\_

Patient Primary Phone Number: \_\_\_\_\_

### Diagnosis (select one):

G35 Relapsing Remitting Multiple Sclerosis

Other: ICD 10 Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

### Pre-Medications: \*\*administered 30 minutes prior to infusion\*\*

None

Acetaminophen 650 mg PO

Diphenhydramine: Dose:  25 mg  50 mg Route:  PO or  IVP

Methylprednisolone: Dose:  40 mg or  125 mg Route: IVP

Famotidine: Dose: 20 mg Route:  PO or  IVPB

Other (include drug, dose, and route): \_\_\_\_\_

### Drug Orders:

• Natalizumab (Tysabri) (J2323) 300 mg per 100 mL Sodium Chloride 0.9% IV to infuse over 1 hour once every 4 weeks

• Order Duration: Six months unless otherwise specified (Other: \_\_\_\_\_)

### Standing Orders:

• Monitor patient for 1 hour following completion of infusion.

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Pre-Screening Requirements:**

- Ensure prescriber is enrolled in the MS Touch Prescribing Program and that the patient has current Notice of Patient Authorization on file. Send copy with completed treatment plan to Infusion Services. Infusion Services will complete and submit the pre-infusion patient checklist prior to each treatment.
- Provide anti-JCV antibody results prior to start of therapy and within the last 6 months

**Previous Therapies:**

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received natalizumab at another facility, please provide last date received: \_\_\_\_\_
- If patient has previously received another biologic therapy, please provide the name: \_\_\_\_\_ and the last date received: \_\_\_\_\_

**Insurance Information:**

Insurance Plan Name: \_\_\_\_\_

Insurance Identification Number: \_\_\_\_\_

Insurance Customer Service Contact Number: \_\_\_\_\_

**Preferred Treatment Location**

- McLeod Regional Medical Center (Florence)     McLeod Health Loris     McLeod Health Cheraw
- McLeod Health Seacoast (Little River)     McLeod Health Dillon     McLeod Health Clarendon (Manning)

**Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at [medicationaccessteam@mcleodhealth.org](mailto:medicationaccessteam@mcleodhealth.org).**