Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____ Height:_____

Allergies: _____

Tysabri Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

Diagnoses:

- ☐ Multiple Sclerosis, Relapsing-remitting — ICD-10: G35.A
- ☐ Multiple Sclerosis, Active secondary progressive — ICD-10: G35.C1
- ☐ Multiple Sclerosis, Unspecified — ICD-10: G35.D
- ☐ Crohn's disease — ICD-10: _____
- ☐ Other: _____ ICD-10: _____

Has patient received Tysabri before? ☐ No ☐ Yes (date of last infusion: _____)

Medication Orders:

- Tysabri (natalizumab) ☐ 300 mg/100 ml NS IV over 1 hour every 4 weeks
  ☐ Other dose/instructions: _____
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- If no central IV access, RN to insert peripheral IV, rotate sites as needed, and remove at end of therapy.
- Monitor for infusion reactions during infusions.
- Observe for at least 1 hour after completion for the first 12 infusions; subsequent monitoring period to be determined by clinical judgment if no hypersensitivity reaction has been observed.
- Other: _____

_____

Labs:

☐ CBC w/diff	☐Each infusion	☐Other frequency_____
☐ CMP	☐Each infusion	☐Other frequency_____
☐ Hepatic function panel	☐Each infusion	☐Other frequency_____
☐ T cell subsets (Lymphocyte panel)	☐Each infusion	☐Other frequency_____
☐ JC Virus Antibody with Index	☐Each infusion	☐Other frequency_____
☐ Tysabri Antibody	☐Each infusion	☐Other frequency_____
☐ TSH	☐Each infusion	☐Other frequency_____
☐ Vitamin D	☐Each infusion	☐Other frequency_____
☐ Other: _____	☐Each infusion	☐Other frequency_____
☐ Other: _____	☐Each infusion	☐Other frequency_____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name

KEY: ◆ Orders are initiated unless crossed out by provider. **❑ Check box to initiate order.**

Form # 351
Updated 9/26/2025 - jrh