ADVANCED
INFUSION CENTER

Tysabri Infusion Orders

Patient Name: _____DOB: _____ Phone: _____

Weight: _____ lbs. Allergies: _____

Diagnosis: Multiple Sclerosis (ICD 10 code: G35)

MS Type: ___ Relapsing-Remitting ___ Secondary-Progressive ___ Clinically Isolated

Tysabri Order:

___ 300 mg IV every 28 days x1 year ____ other: _____

___ 300 mg IV every _____ weeks x 1 year

Pre-Medications:

___ acetaminophen 650 mg ___ loratadine 10 mg po ___ diphenhydramine 25 mg po

Additional pre-medication:

___ Solu- Medrol 100 mg IVP ___ Hydration: _____

Lab Orders: _____

Hypersensitivity Reaction Order:

- Stop Tysabri and start 0.9% normal saline 250 ml Bolus.
- Give diphenhydramine 50 mg IVP.
- Give Solu- Medrol 125 mg IVP.
- Notify physician.

Physician Signature: _____ **Date:** _____

Physician Name (please print):

Office phone: _____ **Fax:** _____

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