NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Tysabri (Natalizumab) Order Form – J2323

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Please list any premeds needed here:_____

PATIENTS/PROVIDERS MUST BE ENROLLED IN THE TOUCH REMS PROGRAM

☐ **Patient is enrolled in the TOUCH REMS program through__/__/__.**

☐ **Multiple sclerosis: IV: 300 mg infused over 1 hour every 4 weeks**

☐ **Multiple sclerosis: IV: 300 mg infused over 1 hour every 6 weeks**

Orders valid through__/__/____ *MAX OF 6 MONTHS*

☐ **Crohn disease: IV: 300 mg infused over 1 hour every 4 weeks**

Orders valid through__/__/____ *MAX OF 6 MONTHS*

* **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____