SPECIALTY INFUSION CENTER
An Access Infusion Care Company

NATALIZUMAB ORDERS

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CBC/CMP/HepB screening
☐ MRI results
☐ Completed and Signed Referral
Usual Dx Codes: Relapsing-remitting multiple sclerosis (G35.A) Multiple sclerosis, unspecified (G35.D) Primary progressive multiple sclerosis, active (G35.B1) Primary progressive multiple sclerosis, unspecified (G35.B0) Primary progressive multiple sclerosis, non-active (G35.B2) Secondary progressive multiple sclerosis, unspecified (G35.C0) Secondary progressive multiple sclerosis, non-active (G35.C2) Secondary progressive multiple sclerosis, active (G35.C1)
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

NATALIZUMAB ORDERS

CENTERS AT SIC
An Access Infusion Care Managed Company

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS
☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance info ☐ H&P/labs/tests/progress notes supporting dx	
• Prior Therapies:	
☐ Hepatitis B Screening: ☐ Positive ☐ Negative-Date:	☐ JCV antibody test result
MS Dx: Last therapy	Last treatment date:
Date of last MRI: Changes? ☐ Yes ☐ No	
Is the patient currently enrolled in the TOUCH (FDA REMS) program? ☐ Yes ☐ No	

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Other ☐ JCV Antibody every

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐ **Natalizumab** ☐ **Specific Product (optional):**	300mg/15mL	☐ 300 mg every 4 weeks ☐ 300mg every weeks ☐ 300mg every days Infuse in 100ml 0.9%NS IV over 60 minutes	☒ 1 vial Refills:

If no product is specified, an insurance-preferred biosimilar may be used.
If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION Observe the patient for at least 60 minutes after the infusion.

☐ Patient has had 12 infusions without evidence of hypersensitivity and does not require post-infusion observation

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834