Holland Hospital

AMBULATORY TREATMENT UNIT

Ambulatory Treatment Unit
Phone (616) 394-3547
Fax (616) 394-2139

Tysabri (natalizumab) / Tyruko (natalizumab-sztn) Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

PRE-MEDICATIONS

When ordering pretreatment medication(s), please select appropriate formulation.

- ☐ Acetaminophen - *650 mg, Oral: Tab. Give prior to treatment.*
- ☐ Cetirizine 10 mg PO. *Give prior to treatment.*
- ☐ Solumedrol 40 mg IV Push. *Give prior to treatment.*
- ☐ Other: _____

MEDICATIONS

- ☐ Tysabri (natalizumab) 300 mg IV q 4 weeks
- ☐ Tyruko (natalizumab-sztn) 300 mg IV q 4 weeks

- Monitor for infusion related reactions for 1 hour post infusion for the first 12 infusions
- Check for active infection. If there is an active infection, dose should be held. Contact provider for guidance whether to continue treatment.
- Check that patient is authorized to receive medication and complete checklist prior to administration.

Treatment for Adverse Drug Reactions (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". (Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O_2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO_2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

☑ **By signing this order, the prescribing provider attests that they are certified and enrolled in the applicable REMS program for these medications and confirms that patient enrollment and all required REMS documentation/forms have been completed. The provider is responsible for educating the patient on the risks and benefits of therapy, including the risk of progressive multifocal leukoencephalopathy (PML). The provider assumes responsibility for ongoing patient monitoring and compliance with all REMS program requirements.**

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____