LEMTRADA® Referral Form





Fax completed form to: 833-908-1122

PATIENT INFORMATION							
Patient Name:	Date of Birth:		- :	Referral Date:			
Address:			City/State/Zip:				
Home Phone:	Ce	ell Phone:	,		Work Phone:		
Secondary Contact:	H	eight: Weight:			Male Female		
Patient Diagnosis & ICC	-10:						
Allergies:							
		PROVIDER INFO	RMATIO	N			
Physician Name:	Li	c.#:		DEA #:			
Practice Name:				NPI#:			
Address:				City/State/Zip) <u>:</u>		
Office Contact: Phone:			Fax:				
Supervisory Physician (fapplicable):						
MS CLINICAL DETAILS							
Type of MS: Primary progressive multiple sclerosis (PPMS) <i>OR</i> Relapsing multiple sclerosis (RMS)							
Ambulation status:	Ambulation status: Able to ambulate more than 5 meters Able to ambulate without aid or rest for at least 100 meters						
Relapse details: Two or more relapses within the previous two years One relapse within the previous year							
PLEASE ATTACH							
Patient demograph	cs & front/back copy of all insurance cards (prescri			ım creatinine l	evels, urinalysis with cell counts, urine protein to	creatinine ratio	
Recent office visit n	otes, history & physical, lab & pertinent procedure	recility 1 /	ınction tests				
	list & list of prior medications tried and failed (with	Pregnanc	y test results (if				
	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	vaccine sc			umentation of any recent vaccinations		
Line access docume	ntation/verification if applicable				g or indication is outside of FDA guidelines		
		NURSING & LAB	ORDERS				
Nurse Orders: Nurse to	provide assessment, teaching, lab draws, medica	ntion administration and vascular acce	ess device insert	ion and/or ma	nagement per physician orders.		
Flush Orders: NaCl 0.9	% - 5-10mL flush pre and post infusion and as nea	eded <i>Heparin</i> - 10units/mL 0)R 100uni	ts/mL - 3-5mL	flush after post-infusion NS flush if indicated to r	naintain line	
		,					
Oxygen: Give O ₂ at 2L/M per nasal cannula as needed							
Lab Orders:							
		SUPPLY ORI	DERS				
	plies for vascular access line care, drug administra	SUPPLY ORI	DERS	essary			
	plies for vascular access line care, drug administra	SUPPLY ORI	DERS provided as nece	•		REFILLS	
Supply Orders: All sup PRODUCT	plies for vascular access line care, drug administra Yes No If No, when was last dose given?	SUPPLY ORI tion kit(s), pump, and IV pole will be PRESCRIPTION II	DERS provided as nece	TION		REFILLS	
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Supply Orders: All sup PRODUCT	Yes No If No, when was last dose given? Pre Meds: Hydroxyzine HCI 50mg po prior t	SUPPLY ORI tion kit(s), pump, and IV pole will be PRESCRIPTION II When is patien to start of infusion and every 6 hours p	provided as neces NFORMA nt due for next of prn #25	TION lose?	ichever occurs later #60 Refill: #1	REFILLS	
Supply Orders: All sup PRODUCT	Yes No If No, when was last dose given? Pre Meds: Hydroxyzine HCl 50mg po prior t Acyclovir 200mg po BID for a minimum of 2	SUPPLY ORI tion kit(s), pump, and IV pole will be PRESCRIPTION II When is patien to start of infusion and every 6 hours p months or until CD4+ count is > or =	provided as necessary	TION lose?		REFILLS	
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Supply Orders: All sup PRODUCT Is this a first dose? LEMTRADA ANAPHYLAXIS / SIDE EFFECT	Yes No If No, when was last dose given? Pre Meds: Hydroxyzine HCl 50mg po prior to Acyclovir 200mg po BlD for a minimum of 2 Cetirizine 10mg po prior to Lemtrada infusio Promethazine 25mg po prior to start of Note — If needed, please send pain present present saline 0.9% 500ml IV prior to Lemtra Initial Course: 12mg/day IV infusion via Subsequent Course: 12mg/day IV infusion Post Meds: Normal saline 0.9% 500ml. IV in Ondansetron 4-8mg in 50-100ml. 0.9% Nac	SUPPLY ORI tion kit(s), pump, and IV pole will be PRESCRIPTION II When is patien to start of infusion and every 6 hours pump the scription to retail pharmacy on in 500mL of 0.9% NaCl over 1 hour ada infusion on days 4 and 5 pumpOR gravity over 4 ho via pumpOR gravity over 1 infusion over 1 hour post Lemtrada in CI IV infusion over 15 minutes prn nace	provided as necon NFORMA and due for next or prin #25 = to 200 cells per Ondansetron Famotidine 2 Other: prior to Lemtrad urs for 5 consect 4 hours for 3 confusion usea	r microliter, wh 4mg po prin #2 0mg prior to st a infusion on da utive days secutive days *	25 cart of alemtuzumab infusion 	REFILLS	
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Prescriber's Signature Dispense as Written

Print Name

Date

Prescriber's Signature **Substitution Permitted** **Print Name**

Date





