# LEMTRADA® Referral Form

amerita specialty infusion services

InfusionRx an amerita company

**Fax Completed Form To:** **Phone:**

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Referral Date: |
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | ☐ Male ☐ Female |
| Patient Diagnosis & ICD-10: | | |
| Allergies: | | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | | NPI#: |
| Address: | | City/State/Zip: |
| Office Contact: | Phone: | Fax: |
| Supervisory Physician (if applicable): | | |

## MS CLINICAL DETAILS

**Type of MS:** ☐ Primary progressive multiple sclerosis (PPMS) ***---OR---*** ☐ Relapsing multiple sclerosis (RMS)

**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 demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Line access documentation/verification if applicable
- ☐ CBC with differential, Serum creatinine levels, urinalysis with cell counts, urine protein to creatinine ratio thyroid function tests
- ☐ Pregnancy test results (if applicable)
- ☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

## NURSING & LAB ORDERS

**Nurse Orders:** Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

**Flush Orders:** *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line

**Oxygen:** Give $O_2$ at 2L/M per nasal cannula as needed

**Lab Orders:** **Lab Date & Frequency:**

## SUPPLY ORDERS

**Supply Orders:** All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

| PRODUCT | PRESCRIPTION INFORMATION | REFILLS |
|---|---|---|
| | Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____ | |
| ☐ LEMTRADA | ☐ **Pre Meds:** Hydroxyzine HCl 50mg po prior to start of infusion and every 6 hours prn #25<br>Acyclovir 200mg po BID for a minimum of 2 months or until CD4+ count is > or = to 200 cells per microliter, whichever occurs later #60 Refill: #1<br>Cetirizine 10mg po prior to Lemtrada infusion<br>Ondansetron 4mg po prn #25<br>Promethazine 25mg po prn #25<br>Famotidine 20mg prior to start of alemtuzumab infusion<br>Acetaminophen 1000mg po prior to start of Lemtrada infusion and q6h prn<br>Other:_____<br>**Note – If needed, please send pain prescription to retail pharmacy**<br>☐ **Pre Infusion:** Solu-Medrol 1000mg IV infusion in 500mL of 0.9% NaCl over 1 hour prior to Lemtrada infusion on days 1, 2 and 3 only<br>Normal saline 0.9% 500ml IV prior to Lemtrada infusion on days 4 and 5<br>☐ **Initial Course:** 12mg/day IV infusion via ☐ pump ***---OR---*** ☐ gravity over 4 hours for 5 consecutive days<br>☐ **Subsequent Course:** 12mg/day IV infusion via ☐ pump ***---OR---*** ☐ gravity over 4 hours for 3 consecutive days *To start at least12 months after previous dose*<br>☐ **Post Meds:** Normal saline 0.9% 500mL IV infusion over 1 hour post Lemtrada infusion | _____ |
| ☐ ANAPHYLAXIS / SIDE EFFECT ORDERS | ☐ Ondansetron 4-8mg in 50-100mL 0.9% NaCl IV infusion over 15 minutes prn nausea<br>☐ Epinephrine 1:1000 0.5-1mL IVP prn angioedema/hypotension/branchospasm/generalized urticaria<br>☐ Ketorolac: 30mg IVP over 3-5 minute<br>☐ Diphenhydramine 50mg in 100mL of 0.9% NaCl IV over approx 15 mins prn pruitis/rash | _____ |
| ☐ OTHER | | _____ |

***By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.***

**Prescriber's Signature** **Print Name** **Date**
**Dispense as Written**

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

*©2024 Amerita Inc. All rights reserved.*
*AME IRX_LEMTRADA REFER 6.24*

ameritaiv.com

ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy