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 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 Cetirizine 10mg po prior to Lemtrada infusion Ondansetron 4mg po prn #25 Promethazine 25mg po prn #25 Famotidine 20mg prior to start of alemtuzumab infusion Acetaminophen 1000mg po prior to start of Lemtrada infusion and q6h prn Other:_____ **Note – If needed, please send pain prescription to retail pharmacy** ☐ **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 Normal saline 0.9% 500ml IV prior to Lemtrada infusion on days 4 and 5 ☐ **Initial Course:** 12mg/day IV infusion via ☐ pump ***---OR---*** ☐ gravity over 4 hours for 5 consecutive days ☐ **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* ☐ **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 ☐ Epinephrine 1:1000 0.5-1mL IVP prn angioedema/hypotension/branchospasm/generalized urticaria ☐ Ketorolac: 30mg IVP over 3-5 minute ☐ 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

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URAC ACCREDITED Specialty Pharmacy 06/01/2020 ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy