

LEMTRADA® Referral Form



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:	<input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Primary progressive multiple sclerosis (PPMS) ---OR--- <input type="checkbox"/> Relapsing multiple sclerosis (RMS)
Ambulation status: <input type="checkbox"/> Able to ambulate more than 5 meters <input type="checkbox"/> Able to ambulate without aid or rest for at least 100 meters
Relapse details: <input type="checkbox"/> Two or more relapses within the previous two years <input type="checkbox"/> One relapse within the previous year

PLEASE ATTACH	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical)	<input type="checkbox"/> CBC with differential, Serum creatinine levels, urinalysis with cell counts, urine protein to creatinine ratio thyroid function tests
<input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results	<input type="checkbox"/> Pregnancy test results (if applicable)
<input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)	<input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations
<input type="checkbox"/> Line access documentation/verification if applicable	<input type="checkbox"/> 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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> LEMTRADA	<input type="checkbox"/> 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	_____
<input type="checkbox"/> ANAPHYLAXIS / SIDE EFFECT ORDERS	<input type="checkbox"/> 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 <input type="checkbox"/> Initial Course: 12mg/day IV infusion via <input type="checkbox"/> pump ---OR--- <input type="checkbox"/> gravity over 4 hours for 5 consecutive days <input type="checkbox"/> Subsequent Course: 12mg/day IV infusion via <input type="checkbox"/> pump ---OR--- <input type="checkbox"/> gravity over 4 hours for 3 consecutive days *To start at least 12 months after previous dose* <input type="checkbox"/> Post Meds: Normal saline 0.9% 500mL IV infusion over 1 hour post Lemtrada infusion	_____
<input type="checkbox"/> OTHER	<input type="checkbox"/> Ondansetron 4-8mg in 50-100mL 0.9% NaCl IV infusion over 15 minutes prn nausea <input type="checkbox"/> Epinephrine 1:1000 0.5-1mL IVP prn angioedema/hypotension/bronchospasm/generalized urticaria <input type="checkbox"/> Ketorolac: 30mg IVP over 3-5 minute <input type="checkbox"/> Diphenhydramine 50mg in 100mL of 0.9% NaCl IV over approx 15 mins prn pruitis/rash	_____

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



ACHC ACCREDITED

