

LEMTRADA[®] Referral Form

Fax Completed Form To: 877-418-4495 Phone: 877-418-4114



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 least 12 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/bronchospasm/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.			

<u>Prescriber's Signature</u> Dispense as Written	Print Name	Date	<u>Prescriber's Signature</u> Substitution Permitted	Print Name	Date
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ACHC ACCREDITED

