Lemtrada
(alemtuzumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ G35.A (RRMS) ☐ G35.B0 (PPMS-NOS) ☐ G35.B1 (Active PPMS) ☐ G35-B2 (Non-active PPMS)

☐ G35.C0 (SPMS-NOS) ☐ G35.C1 (Active SPMS) ☐ G35.C2 (Non-Active SPMS) ☐ G35.D (MS-NOS)

PRESCRIPTION

☐ **First Treatment Course:** Lemtrada 12mg IV daily for 5 consecutive days

☐ **Second Treatment Course:** Lemtrada 12mg IV daily for 3 consecutive days, administered 12 months after first treatment course.

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- MRI
- Most recent labs including (TSH, Scr, CBC, Ua with cell counts, AST, ALT, total bilirubin)
- Recommend: HIV, Varicella Zoster antibodies
- Tried/failed therapies
- TB screening
- REMS enrollment paperwork

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. *(See aiscaregroup.com for detailed policy)*

- Epinephrine (weight based dosing) PRN per protocol
- Famotidine PRN per protocol
- Diphenhydramine PRN per protocol
- 0.9% Sodium Chloride PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: Solu-medrol 1 gram IV on days 1-3 of each course, Tylenol 1000mg PO, Benadryl 25mg IV, and Pepcid 20mg IV prior to infusion.

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.