## Lemtrada

(alemtuzumab)

Prescriber Signature: \_



PATIENT DEMOGRAPHIC INFORMATION				
				Phono
Patient Name:Addres	29:			Phone:
-				
PRIMARY DIAGNOSIS	ODMO			
Multiple sclerosis (G35) RRMS Other:	SPMS			
PRESCRIPTION				
First Treatment Course: Lemtrada 12mg IV da				
Second Treatment Course: Lemtrada 12mg IV		ecutive	e days, adminis	tered 12 months after first treatment cours
Other:  Has patient received any doses of this medication in		 ⁄es	No	
Thas patient received any doses of this medication in	Tille past:	163	INO	
REQUIRED DOCUMENTATION				
•Insurance Card •MRI				• Tried/failed therapies
<ul><li>+H&amp;P</li><li>• Most recent labs</li><li>• Patient Demographics</li><li>cell counts, AST</li></ul>			CBC, Ua with	•TB screening
<ul><li>Patient Demographics cell counts, AST</li><li>Medication List</li><li>Recommend: H</li></ul>			ihodies	• REMS enrollment paperwork
- Medication List	1 1, 1 4 1 1 0 0 1 4 2 0 0	nor arr		
ANCILLARY ORDERS				
ADVERSE REACTION & ANAPHYLAXIS ORDERS				
Administer acute infusion and anaphylaxis me	edications per A	dvanc	ed	
Infusion Care Centers' protocol. (See aiscaregro			no DDN nor protoc	
Epinephrine (weight based dosing) PRN per protocol     Famotidine PRN per protocol		-	ne PRN per protoc hloride PRN per pr	
Other: Please fax other reaction orders if chec	king this box			
PRE-MEDICATION ORDERS PROTOCOL				
Per infusion center protocol: Solu-medrol 1 gra	am IV on davs 1-	3 of ea	ach course. Tyle	enol 1000mg PO. Benadryl 25mg IV. and
Pepcid 20mg IV prior to infusion.	arriv orradyor	00100	torroouroo, ryn	sherred enigree, behaving try, and
Provider Prescribed:				
LINE CARE ORDERS				
Start PIV/Access CVC Flush device pe	er Advanced Inf	usion (	Care Centers' p	orotocol (See aiscaregroup.com for detailed policy
Other Flush Orders: Please fax other line care				
LAB ORDERS—PLEASE INCLUDE FREQUENCY				
Please list any labs to be drawn by the infusion	clinic:			
PRESCRIBER INFORMATION				
Prescriber Name:				Phone:
NPI:				
Office Contact Person:		En	nail:	

Fax: 855.217.1930 | Phone: 800.482.8466 | Email: AICCreferrals@aiscaregroup.com | Visit: aiscaregroup.com/patient-referral-forms/

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

Date: