

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD-10 CODE

Relapsing-Remitting Multiple Sclerosis (RRMS) ICD-10 Code: _____
 Other Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

This signed order form by the provider Clinical/Progress notes supporting primary diagnosis
 Patient demographics AND insurance information Labs and Tests supporting primary diagnosis
 TB test results Pregnancy Test (if applicable)
 Baseline Labs: TSH, Cr, CBC, Ua with cell counts (within 30 days), and AST, ALT, total bilirubin (within 3 months)

Is the ordering PROVIDER enrolled in the Lemtrada REMS program? Yes No (must be enrolled to start therapy)

Is the patient enrolled in the Lemtrada REMS program? Yes No (must be enrolled to start therapy)

Please indicate which antiviral prophylaxis medication has been prescribed for your patient: _____

Please list tried and failed therapies:

1)
2)

MEDICATION ORDERS

Dosing First Course: Lemtrada 12 mg IV daily for 5 consecutive days
 Second Course: Lemtrada 12 mg IV daily for 3 consecutive days, to be given approximately 12 months after initial course
 Other: _____

Administer each dose over 4 hours and monitor for 2 hours after infusion completion.
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

Acetaminophen 650mg PO prior to infusion Other: _____
 Diphenhydramine 25mg PO prior to infusion Other: _____
 Methylprednisolone 1 gram IV prior to infusion on days 1-3 of each course Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____