

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: ☐ 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 pruritis/rash	_____
☐ OTHER		_____
<i>By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.</i>		

Prescriber's Signature

Print Name

Date

Prescriber's Signature

Print Name

Date