



# Lemtrada® Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com  Initial Order  Reorder

**Demographics Information:** Today's Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: GA Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_  Cell Alternate Phone #: \_\_\_\_\_  Cell

**Height:** \_\_\_\_\_ in/ft **Weight:** \_\_\_\_\_ lbs/kg Date weight recorded: \_\_\_\_\_ **Last 4 of SSN:** \_\_\_\_\_

Allergies: \_\_\_\_\_  NKDA

**Diagnosis Information:**  Multiple Sclerosis Relapsing G35

Other Diagnosis/ICD10Code \_\_\_\_\_

Date Infusion to Begin: _____	<b>Is this a first infusion?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Date of Last Infusion:</b> _____
List Reactions: _____	<b>List of Failed Therapies:</b> _____

**Assessment Questions:** *Please Provide Appropriate Documentation*

Diabetes?  Yes  No HTN?  Yes  No Cardiac History?  Yes  No Difficulty Breathing?  Yes  No

Requires Oxygen?  Yes  No Confusion /Disorientation?  Yes  No Neuro History?  Yes  No

**TB test:** \_\_\_\_\_ **HBsAG:** \_\_\_\_\_ **HIV test results:** \_\_\_\_\_

**Lemtrada (Alemtuzumab)®: J0202**  **Provider Reviewed FDA/REMS recommendations**

**Initial Dose:** 12 mg/day IV over 4 hours for 5 consecutive days: *Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion*

**Maintenance Dose:** 12 mg/day IV over 4 hours for 3 consecutive days 12 months after initial dose: *Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion*

**Pre-Medications: Patient to Provide and take 30 minutes prior to infusion**

Benadryl 25 MG PO x1  Benadryl 50 mg PO x1

Acetaminophen 325 mg PO x1  Acetaminophen 650 mg PO x1

Other Pre-medication: \_\_\_\_\_

<p><b>Access:</b> <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5ml: Qty 3</p> <p>PORT – NS 10ml: Qty 2, Heparin 5mL 100units/mL x 1 per infusion</p> <p>PICC – NS 10ml: Qty 2, Heparin 5mL 10units/mL x 1 per infusion</p>	<p><b>Supplies:</b> (please strike through if not required)</p> <p>Administration Supplies (A4222) – 2 per infusion</p> <p>Catheter Care Supplies (A4221) – 1 per week</p> <p>Infusion Pump (E0781)</p> <p>Nursing services to administer medications</p> <p><b>Administer the anaphylaxis protocol for adverse reactions</b></p>
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Provider signature: \_\_\_\_\_

NPI # \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Office Address: \_\_\_\_\_ City: \_\_\_\_\_ St \_\_\_\_\_ Zip: \_\_\_\_\_

Printed MD Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Demographic information  Patient Ins. Card  H & P  Office notes  Failed therapies in documentation

Up to date medication list

9/23 TSP