Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

LEMTRADA (ALAMTUZUMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
☐ Required Labs: TSH, CMP, CBC, Ua with cell counts prior to initiation of 1st and 2nd course
(Labs must be within 30 days of initiation of course). PPD or TB Gold prior to initiation of 1st course.
☐ Patient's authorization for Lemtrada REMs Program
☐ Last MRI

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: Multiple Sclerosis (ICD-10: _____)

J Code: J0202

LEMTRADA ORDERS

☐ **Lemtrada Intravenous Dose:** ☐ First course: 12mg/day for 5 consecutive days.
☐ Second course: 12mg/day for 3 consecutive days 12 months after first treatment course.
☐ Other:_____

Protocol Pre-medication Orders: ☐ Solu-Medrol 1gm (days 1-3) of each course ☐ Tylenol 1000mg PO
☐ Benadryl 25mg IV ☐ Pepcid 20mg IV daily prior to infusion.

Post-Infusion Hydration: _____ ml NS for _____ days

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	