Referral Status:				MRN:
	New referral		Order change		Order Renewal
Patient preferred clinic:				

Lemtrada® (alemtuzumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:				
Patient Name:		Address:				
Date of Birth:		City, State, Zip:				
Height in inches:	Weight: LB or KG	Gender:	Allergies:		See list	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

	G35 - Replasing Multiple Sclerosis
	_______ - Other:

REQUESTED DOCUMENTATION: / PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	H&P including Labs and tests supporting diagnosis	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
			NEXT INFUSION DATE:
3	Full medication list including tried and failed therapies		**IF ORDER CHANGE:**
5	Patient enrolled in REMS? Yes No		☐ **Continue current order until insurance approved**
6	TB test results: PPD or QuantiFERON Gold Test		
7	CBC with differential, serum creatinine level, urinalysis with urine cell counts, & TSH levels prior to start of therapy.		
8	Are immunizations current and if any recently given, were they at least 6 weeks prior to start of Lemtrada? Yes No		
9	Has antiviral prophylaxis for herpetic viral infections been prescribed? Yes No		

MEDICATION ORDERS:

NOTE: Patient *may be ineligible* to receive alemtuzumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, severe abdominal pain or vomiting, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED
*Per FDA labeling Premedication of Acetaminophen PO, Diphenhydramine IVP, and Ondansetron IVP is suggested prior to infusion

IV					
Diphenhydramine		25mg		50mg	
Ondansetron		4mg		Other:	
Famotidine		20mg		40 mg	
Other:					

PO								
Acetaminophen		325mg		500mg		650mg		1000mg
Famotidine		20mg		40mg				
Diphenhydramine		25mg		50mg				
Fexofenadine		60mg		180mg				
Cetirizine		10mg						
Loratadine		10mg						
Other:								

MEDICATION/DOSE:

☑ Methylprednisolone 1000 mg given IV over 1 hour in NS diluted per protocol **for the first 3 days of each treatment course** prior to Lemtrada

☑ Lemtrada® (alemtuzumab) 12 mg given IV in 100ml of NS to infuse over 4 hours

FREQUENCY:

☐ First Course: Daily for 5 consecutive days

☐ Second/Subsequent Course: Daily for 3 consecutive days

Each dose followed by two hour post infusion monitoring

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted	

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023

© 2023 Palmetto Infusion Services. All rights Reserved. Confidential Property of Palmetto Infusion Services.