

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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 - Replacing 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:
3	Full medication list including tried and failed therapies		NEXT INFUSION DATE:
5	Patient enrolled in REMS? Yes No	Continue current order until insurance approved	
6	REQUIRED: TB test results for new start patients		
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	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Ondansetron	4mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg		Diphenhydramine	25mg	50mg		
	Other:				Fexofenadine	60mg	180mg		
				Cetirizine	10mg				
				Loratadine	10mg				
				Other:					

MEDICATION/DOSE:

- Methylprednisolone 1000 mg diluted in 50-250mL NS via IV over 1 hour 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
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com