(alemtuzumab)

LEMTRADA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ Length of Need _____

☐ Diphenhydramine 25mg IVP

☐ _____
(other)

☐ _____
(other)

LEMTRADA ORDERS

DOSAGE

☐ 12mg IV each day for 5 consecutive days ◯ Refills: _____

☐ 12mg IV each day for 3 consecutive days - 12 months after first treatment course

PREMEDICATION PER PRESCRIBING INFORMATION

◯ Solu-medrol 1gm IV for days 1-3 of each course

PATIENT WEIGHT

_____ lbs.

_____ kg

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887