RED RIVER HEALTH
Ambulatory Infusion Clinic

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LEMTRADA (alemtuzumab) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Multiple Sclerosis ☐ _____ _____ *(other)*

Pre-Medication:

☐ Tylenol 1000mg PO ☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP

☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*

LEMTRADA ORDERS:

Dosing/Frequency: ☐ 12mg IV each day for 5 consecutive days

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

Pre-Med per Prescribing Information:

☐ Solu-Medrol 1gm IV for days 1-3 of each course

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: