Lemtrada®

Provider Order Form Rev. 09/2025

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Relapsing-Remitting Multiple Sclerosis, G35.A

☐ Active Secondary Progressive Multiple Sclerosis, G35.C1

INFUSION ORDERS

MEDICATION	DOSE, DIRECTIONS, and DURATION
Lemtrada® (alemtuzumab)	☐ **FIRST TREATMENT COURSE:** **Pre-Hydration** • Solu-Medrol 1 gm in 500 mL of 0.9% Sodium Chloride IV over 1 hour on **infusion Days 1, 2 and 3 only** • 500 mL of 0.9% Sodium Chloride IV over 30-60 minutes on **infusion Days 4 and 5 only** **Lemtrada® Treatment** • Infuse 12 mg IV over 4 hours once daily x 5 consecutive days **Post-Hydration** • 500 mL of 0.9% Sodium Chloride IV over 1 hour *Observe patient for 1 hour after completion of post-hydration ☐ **SECOND TREATMENT COURSE: (12 months after first treatment course)** **Pre-Hydration** • Solu-Medrol 1 gm in 500 mL of 0.9% Sodium Chloride IV over 1 hour on **infusion Days 1, 2 and 3** **Lemtrada® Treatment** • Infuse 12 mg IV over 4 hours once daily x 3 consecutive days **Post-Hydration** • 500 mL of 0.9% Sodium Chloride IV over 1 hour *Observe patient for 1 hour after completion of post-hydration

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ Acetaminophen 1000mg PO prior to infusion and Q6H prn

☐ Hydroxyzine 50mg PO prior to infusion and Q6H prn

☐ Ranitidine 150mg PO prior to infusion ☐ Cetirizine 10mg PO prior to infusion

☐ Other: _____ ☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ TSH q _____

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has a relapsing form for Multiple Sclerosis: ☐ Relapsing-remitting multiple sclerosis ☐ Active secondary progress multiple sclerosis ☐ Other: _____

LAB AND TEST RESULTS (required)

- Varicella Zoster Virus (VZV) Antibodies (submit results to start therapy)
- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening (submit results to start therapy)

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____