



LEMTRADA® (ALAMTUZUMAB) ORDER FORM

(* - Required Fields)

New Referral Order Renewal Medication/Order Change
 Benefits Verification Only Discontinuation Order

PATIENT INFORMATION			
NAME*:	DOB*:	SEX:	M F
ADDRESS:	PHONE:		
WEIGHT: LBS KG HEIGHT:	EMAIL:		
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

LEMTRADA ORDER*: <i>(SELECT ONE OF THE FOLLOWING)</i> <input type="checkbox"/> First Course: 12mg/day on 5 consecutive days <input type="checkbox"/> Maintenance Dosing: 12mg/day on 3 consecutive days every 12 months.	ICD-10*: _____
<input type="checkbox"/> Okay to infuse at Multiple Locations	<input type="checkbox"/> Okay to Split Infusions
Physician Signature* _____	Date* (Order is Valid for One Year) _____ <i>Infusion will be administered per MPP policy and protocols</i>

REQUIRED DIAGNOSIS:
<input type="checkbox"/> Relapsing Multiple Sclerosis
<input type="checkbox"/> Other _____

REQUIRED DOCUMENTATION CHECKLIST:
<input type="checkbox"/> Patient Demographics
<input type="checkbox"/> Insurance Card/Information
<input type="checkbox"/> Clinical/Progress Notes supporting DX
<input type="checkbox"/> Current Medication List and H&P
<input type="checkbox"/> HIV Test Results
<input type="checkbox"/> Varicella Zoster Antibodies
<input type="checkbox"/> TB Results (if available)-if positive, need negative chest Xray and negative TSpot
Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC CRP ESRP HFR UA
 Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

-----Colorado-----
 Lakewood

-----Florida-----
 Fort Myers Coming Soon
 Jacksonville
 Kissimmee Coming Soon
 Port St. Lucie
 Winter Park

-----Texas-----
 Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth Coming Soon
 Irving
 Rockwall
 Southlake
 Lewisville
 Plano
 Tyler

REVISION DATE- 11/2019