SPECIALTY INFUSION CENTER
An Access Infusion Care Company

LEMTRADA (ALEMTUZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Relapsing-Remitting Multiple Sclerosis (RRMS) ICD-10 Code: _____

☐ Other Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Clinical/Progress notes supporting primary diagnosis

☐ Patient demographics AND insurance information

☐ Labs and Tests supporting primary diagnosis

☐ TB test results

☐ Pregnancy Test (if applicable)

☐ Baseline Labs: TSH, Cr, CBC, Ua with cell counts (within 30 days), and AST, ALT, total bilirubin (within 3 months)

Is the ordering PROVIDER enrolled in the Lemtrada REMS program? Yes ☐ No (must be enrolled to start therapy)

Is the patient enrolled in the Lemtrada REMS program? Yes ☐ No (must be enrolled to start therapy)

Please indicate which antiviral prophylaxis medication has been prescribed for your patient: _____

Please list tried and failed therapies:

1)

2)

MEDICATION ORDERS

Dosing

☐ First Course: Lemtrada 12 mg IV daily for 5 consecutive days

☐ Second Course: Lemtrada 12 mg IV daily for 3 consecutive days, to be given approximately 12 months after initial course

☐ Other: _____

☐ Administer each dose over 4 hours and monitor for 2 hours after infusion completion.

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion ☐ Other: _____

☐ Diphenhydramine 25mg PO prior to infusion ☐ Other: _____

☐ Methylprednisolone 1 gram IV prior to infusion on days 1-3 of each course ☐ Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

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Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
Fax: (855) 857-3834

Marquette, MI
Phone: (906) 661-1088
Fax: (855) 857-3834