AYSA
THERAPEUTICS INFUSION

LEMTRADA (ALEMTUZUMAB)
ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J0202 Diagnosis: Multiple Sclerosis (ICD-10 Code: _____) Patient Weight: _____

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Last MRI: _____

☐ Patient REMs enrollment paperwork and Prescription Order Form (faxed to MS one to one)

☐ TB Test: Quantiferon Gold, PPD or chest x-ray

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

☐ **Optional Labs (insurance based):** HIV, Varicella Zoster Antibodies

Additional Lab Orders:

LEMTRADA ORDERS

Lemtrada

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

☐ **Second Course(s):** 12mg IV daily for 3 consecutive days, 12 months after previous dose

Protocol Pre-Medication Order: Solu-Medrol 1 gram IV on days 1-3 of each course, Tylenol 1000mg PO, Benadryl 25mg IV, and Pepcid 20mg IV prior to infusion.

Other pre-medication orders: _____

Post-Infusion Hydration:

☐ 500mL NS IV post Lemtrada infusion to run over two hours

☐ Other: _____

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____