



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: _____

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