

Lemtrada (alemtuzumab)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:	Patient Email:			
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

G35 Relapsing Multiple Sclerosis

Other: _____

PRE-MEDICATION ORDERS

administer all pre-meds for the first 3 days of each treatment cycle

administer all pre-meds before each infusion

Methylprednisolone 1,000mg IV

ADDITIONAL PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV

methylprednisolone (Solu-Medrol) 40mgIV 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Lemtrada (alemtuzumab)

Dose and Frequency:

First Course: 12mg/day on 5 consecutive days

Second Course: 12mg/day on 3 consecutive days
12 months after first treatment course

Additional treatment course: 12mg/day on 3
consecutive days given 12 months after the last dose

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date
signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order