Lemtrada® Provider Order Form
Please fax completed referral order form & all required documents to **281-295-4051**

AguaVivir
www.aguavivir.com

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________
Address: ______________________ City/ST/Zip: ______________________
Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required
☐ Multiple Sclerosis, G35

INFUSION ORDERS

MEDICATION	DOSE, DIRECTIONS, and DURATION
Lemtrada® (alemtuzumab)	☐ **FIRST TREATMENT COURSE:** **Pre-Hydration** • Solu-Medrol 1 gm in 500 mL of 0.9% Sodium Chloride IV over 1 hour on **infusion Days 1, 2 and 3 only** • 500 mL of 0.9% Sodium Chloride IV over 30-60 minutes on **infusion Days 4 and 5 only** **Lemtrada® Treatment** • Infuse 12 mg IV over 4 hours once daily x 5 consecutive days **Post-Hydration** • 500 mL of 0.9% Sodium Chloride IV over 1 hour *Observe patient for 1 hour after completion of post-hydration
	☐ **SECOND TREATMENT COURSE: (12 months after first treatment course)** **Pre-Hydration** • Solu-Medrol 1 gm in 500 mL of 0.9% Sodium Chloride IV over 1 hour on **infusion Days 1, 2 and 3** **Lemtrada® Treatment** • Infuse 12 mg IV over 4 hours once daily x 3 consecutive days **Post-Hydration** • 500 mL of 0.9% Sodium Chloride IV over 1 hour *Observe patient for 1 hour after completion of post-hydration

Is patient currently receiving therapy above from another facility?
☐ Yes ☐ No

If yes, Facility Name: ______________________
Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

☐ Acetaminophen 1000mg PO prior to infusion and Q6H prn
☐ Hydroxyzine 50mg PO prior to infusion and Q6H prn
☐ Ranitidine 150mg PO prior to infusion ☐ Cetirizine 10mg PO prior to infusion
☐ Other: ______________ ☐ Other: ______________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time
☐ CBC q ________ ☐ CMP q ________ ☐ TSH q ________
☐ Other: ______________________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________
Physician Name: ______________ Provider NPI: ______________ Specialty: ______________
Address: ______________________ City/ST/Zip: ______________
Contact Person: ______________ Phone #: ______________ Fax #: ______________
Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

☐ Yes ☐ No Does the patient have a relapsing form of Multiple Sclerosis?
If yes, please specify type: ☐ Relapsing-remitting multiple sclerosis
☐ Active secondary progress multiple sclerosis

LAB AND TEST RESULTS (required)

- Varicella Zoster Virus (VZV) Antibodies (submit results to start therapy)
- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening (submit results to start therapy)

PRIOR FAILED THERAPIES

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________