Provider Order Form

# LEMTRADA (ALAMTUZUMAB)

Uptiv Health

## PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

**Patient status:** ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

## DIAGNOSIS ICD-10 code (must be specified)

☐ Multiple Sclerosis (MS) G35 ☐ Relapsing Forms of MS (RMS) G35.11 ☐ Primary Progressive MS (PPMS) G35.2

☐ Other: _____

## PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

## PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

## THERAPY ADMINISTRATION

| Medication | Dose | Frequency |
|---|---|---|
| ☒ Lemtrada (Alamtuzumab), IV in 0.9% sodium chloride, | ☐ 12 mg/day | ☐ First course: Daily for 5 consecutive days |
| | ☐ 12 mg /day | ☐ Second course: Daily for 3 consecutive days 12 months after first treatment course |

Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

## LABORATORY ORDERS

| | | |
|---|---|---|
| ☐ CBC | ☐ at each dose | ☐ every _____ |
| ☐ CMP | ☐ at each dose | ☐ every _____ |
| ☐ CRP | ☐ at each dose | ☐ every _____ |
| ☐ Other _____ | ☐ at each dose | ☐ every _____ |

## SPECIAL INSTRUCTIONS

## PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Hepatitis B Results

☐ HIV Test Results ☐ Baseline ECG ☐ Varicella Zoster Antibodies

Provider Signature _____ Date _____