LEMTRADA (ALEMTUZUMAB) INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing
Lemtrada (alemtuzumab)	□ First Course: 12mg IV daily for 5 consecutive days □ Subsequent Course(s): 12mg IV daily for 3 consecutive days, 12 months after previous dose □ Other: _____

Protocol Pre-Medication Order: Solu-Medrol 1 gram IV on days 1-3 of each course, acetaminophen 1000mg PO, diphenhydramine 25mg IV, and famotidine 20mg IV prior to infusion

Other pre-medication orders: _____

Post-Infusion Hydration: □ 500mL NS IV post Lemtrada infusion to run over two hours
□ Other: _____

Other orders: _____

Lab Orders: _____ Frequency: _____

Required labs to be drawn by: □ LIVbetter □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR LEMTRADA (ALEMTUZUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- □ Include signed and completed order (MD/prescriber to complete page 1)
- □ Include patient demographic information and insurance information
- □ Include patient's medication list
- □ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - □ Has the patient had a documented contraindication/intolerance or failed trial of 2 or more drugs indicated for MS? □ Yes □ No
    If yes, which drug(s)? _____
  - □ Expanded Disability Status Scale (EDSS) score (if available): _____
- □ Labs/tests supporting primary diagnosis attached
  - □ MRI
- □ REMs enrollment paperwork and Prescription Order Form (faxed to MS One to One)
- □ Other medical necessity: _____

REQUIRED PRE-SCREENING

□TB screening test completed within 12 months - attach results

□Positive □ Negative

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

□Recommended labs: HIV, Varicella Zoster Antibodies

*If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)