Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(alemtuzumab)

INFUSE ONE OHIO

LEMTRADA infusion orders

Patient Name _____ DOB _____

Phone _____ M☐ F☐

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis ☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*
☐ _____ *(other)*

LEMTRADA ORDERS

DOSAGE

☐ 12mg IV each day for 5 consecutive days
☐ 12mg IV each day for 3 consecutive days - 12 months after first treatment course

PREMEDICATION PER PRESCRIBING INFORMATION

☑ Solu-medrol 1gm IV for days 1-3 of each course

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES

_____

ORDERING PROVIDER

Provider NPI: _____ Phone_____ Fax_____

Provider Name _____

Provider Address _____

Signature _____ Date_____