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

(alemtuzumab)

LEMTRADA infusion orders

INFUSE ONE

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

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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