BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

LEMTRADA (ALEMTUZUMAB) INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: ______________________________ DOB: __________ Phone: ____________

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Multiple Sclerosis (ICD-10 Code: G35)
☐Other: ____________________ (ICD-10 Code: _________)

MS Type: ☐ RRMS ☐ SPMS

Patient Weight: _______ lbs. (required) Allergies: ________________________________

THERAPY ORDER

Lemtrada

☐**First Course:** 12mg IV daily for 5 consecutive days
☐**Subsequent Course(s):** 12mg IV daily for 3 consecutive days, 12 months after previous dose

Protocol Pre-Medication Order: Solu-Medrol 1 gram IV on days 1-3 of each course, Tylenol 1000mg PO, Benadryl 25mg IV, and Pepcid 20mg IV prior to infusion.

Other pre-medication orders: ____

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

Lab Orders: ____________________________ **Frequency:** ____________________

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: ____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* 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

Provider Name: _________________________ Signature: Date: __________

Provider NPI: ___________ Phone: ___________ Fax: __________ Contact Person: ______________

☐Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: ___________________ State: _________ *View our locations here:*

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

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COMPREHENSIVE SUPPORT FOR LEMTRADA (ALEMTUZUMAB) THERAPY

PATIENT INFORMATION:

Patient 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**

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance

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