LEMTRADA (ALEMTUZUMAB)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

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:** 12 mg IV daily for 5 consecutive days

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

Protocol premedication orders: Solu-Medrol 1 g IV on days 1-3 of each course, Tylenol 1000 mg PO, Benadryl 25 mg IV and Pepcid 20 mg IV prior to infusion.

Other premedication orders: _____

Post-Infusion hydration: ☐ 500 mL NS IV post Lemtrada infusion to run over 2 hours

☐ Other: _____

Lab Orders: _____ **Lab 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 *Hy-Vee Health* 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 Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

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 Prescreening

- ☐ **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**

Hy-Vee Health 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.

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