Hy-Vee health INFUSION CARE

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 __________

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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 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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