Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

(alemtuzumab)

INFUSE ONE

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

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____