OKLAHOMA INFUSION SERVICES

1701 Renaissance Blvd, Ste. 110
Edmond, OK 73013-5853
Phone: (405) 844-4978; Fax: (405) 844-0562

Lemtrada Order Form

Patient's Information

Patient's Name:	Patient's Date of Birth:	Patient's Phone:	Gender: M ☐ F ☐
Patient's Address:	Patient's Email:	Insurance:	

Additional Information

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ G35 Multiple Sclerosis
Type: ☐ Relapsing-Remitting ☐ Primary-Progressive ☐ Secondary-Progressive ☐ Progressive-Relapsing
☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____
☐ Date of Last Brain MRI: _____
☐ Rebif: Date Last Taken: _____ Dose: _____ ☐ Betaseron: Date Last Taken: _____ Dose: _____
☐ Tysabri: Date Last Taken: _____ Dose: _____ ☐ Avonex: Date Last Taken: _____ Dose: _____

Lab Orders

☐ Lab Orders: ☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
☐ Lab Orders to be drawn by: ☐ Oklahoma Infusion Services ☐ Referring Provider

Prescription Information

☐ Lemtrada	☐ Dose: First Course: 12mg/day for 5 consecutive days ☐ Dose: Second Course: 12mg/day for 3 consecutive days 12 months after First Course

Pre-Medication Orders

☐ Solu-Medrol 1000mg IV ☐ Benadryl 25mg IV Push (SIVP)
☐ Tylenol tablet 500-1000mg PO PRN ☐ Claritin 10mg PO PRN
☐ Zantac 150mg PO PRN

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Solu-Cortef 100mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: _____

Prescriber's Information		Prescriber's Contact Person
Prescriber's Name:		Contact Name:
NPI #:	DEA #:	Contact Phone:
Prescriber's Signature:		Contact Fax:
Date:		

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.