Lemtrada Infusion Order

Fax 281-715-5302 Phone 281-265-0100

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ G35 Multiple Sclerosis

◯ Other: _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD 10 : _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

LEMTRADA ORDER

Lemtrada Dose: ◯ 12 mg **Patients Weight:** _____

Frequency: ◯ 1st year (5 days consecutively) ◯ 2nd year (3 days consecutively)

PreMeds: ☐ Benadryl 50mg (oral) ☐ Tylenol 500-1000mg (oral)

Date of last Lentrada Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____