

LEMTRADA (ALEMTUZUMAB) Referral Order Form



WWW.PACEINFUSION.COM

PH: 330-625-4900

F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change
(New Order Required) ☐ Benefits Verification Only ☐ D/C Infusions
*indicate name of drug(s)

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____

LEMTRADA MEDICATION ORDERS

Dose: ☐ 12 mg

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

Pre-medications (30min prior to infusion): ☐ Benadryl 50mg (oral) ☐ Tylenol 500-1000mg (oral)

INDICATION/DIAGNOSIS

NOTES (ADDITIONAL INFO)

- ☐ G35 Relapsing MS
☐ Chronic Immune Thrombocytopenia purpura (ITP)
☐ Primary Humoral Immunodeficiency (PI)
☐ Primary Immunodeficiency (PID)
☐ Other _____

*ICD-10 _____ required

Referring Physician's Signature

Date

REQUIRED DOCUMENTATION

- ☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
(w/in past 6 months)
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ☐ Baseline CBS with differential ☐ Urinalysis with urine cell counts ☐ Comprehensive Metabolic Panel
☐ SCR ☐ TSH CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY

01/2019