Lemtrada® (alamtuzumab) Referral Form

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

CBC At each dose Every ______________________
CMP At each dose Every ______________________
CRP At each dose Every ______________________
Other ____

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: ____
Dose: _____________________ Route: __________________
Frequency: ____

LEMTRADA THERAPY ADMINISTRATION

First Course: 12mg/day on 5 consecutive days

Maintenance Dosing: 12 mg/day on 3 consecutive days every 12 months

Okay to Infuse at Multiple Locations

Okay to Split Infusoins

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

HIV Test Results

Varicella Zoster Antibodies

Baseline ECG

TB Results-if positive, need negative CXR and negative T-Spot

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (786)460-6044

Fax Referral Form To: (786)219-3917

8684 SUNSET DRIVE MIAMI FL 33143