



Lemtrada Order Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Multiple Sclerosis ICD 10 (_____) Other (specify): _____ Ensure patient has taken & prescribed anti-viral: Acyclovir 400 mg

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

LEMTRADA

- Initial (Year One)
- Administer 12 mg daily for 5 days IV
- Maintenance (Year Two/Subsequent Frequent Course)
- Administer 12 mg daily for 3 days

- Vital signs per HI Protocol
- Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

- Acetaminophen 500mg 650mg 1000mg PO
- Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
- Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
- Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
- Prednisone _____ mg PO
- Other: _____

POST-MEDICATIONS N/A

- Acetaminophen 500mg 650mg 1000mg PO
- Prednisone _____ mg PO
- Other: _____

6. LABS

- | | | |
|--|--|---|
| <input type="checkbox"/> CBC w/Diff | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> ESR | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Renal Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
- Quantiferon TB Gold, annually, last completed (date): _____
- Other (specify): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE