



Phone: (865) 862 - 4557

www.heartlandinfusion.com

Fax: (865) 862 - 4556
Alt. Fax: (865) 867 - 7081

Lemtrada Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status:	<input type="checkbox"/> New referral	<input type="checkbox"/> Dose or frequency change	<input type="checkbox"/> Order Renewal
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PATIENT INFORMATION

Name: _____			
Home Phone: _____		Cell Phone: _____	
Email: _____		Last four Social Security number _____	
DOB: _____		Height: _____	Weight: _____
Allergies: _____			
ICD-10 Diagnosis Code: _____		Years with Disease: _____	
TB Test (Circle One):	Skin	Quantiferon	Chest Xray
			Result: _____
			Date: _____

LABORATORY ORDERS

<input type="checkbox"/> CBC w/ Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> Quantiferon TB (annually)		Due: _____
<input type="checkbox"/> Other	_____	

Therapy Orders

Induction (year one): Administer 12 mg Lemtrada (alemtuzumab) IV daily for 5 days

Maintenance (year two/subsequent frequent course): Administer 12 mg Lemtrada (alemtuzumab) IV daily for 3 days

Nursing per Heartland Nursing Procedures (incl reaction management)

<input type="checkbox"/> Pre-Medications		<input type="checkbox"/> No routine pre-medications required
<input type="checkbox"/> Tylenol (acetaminophen) _____ mg PO		<input type="checkbox"/> Zyrtec (cetirizine) 10 mg PO
<input type="checkbox"/> Solu-Medrol (methylprednisolone) _____ mg IV		<input type="checkbox"/> Claritin (loratadine) 10 mg PO
<input type="checkbox"/> Benadryl (diphenhydramine) _____ mg	<input type="checkbox"/> PO	<input type="checkbox"/> IV
<input type="checkbox"/> Other: _____	_____	

PHYSICIAN INFORMATION

Physician's Name: _____		
License #:	NPI#:	DEA#:
Address: _____		
City:	State:	Zip:
Office Contact:	Email: _____	
Office Phone:	Office Fax: _____	

Physician Signature: _____ Date: _____

Patient is being referred to: Knoxville Morristown Kingsport