Fax: 832-895-4040
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adaptIV infusion

Lemtrada (Alemtuzumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

SUPPORTING DOCUMENTATION

☐ Ensure baseline labs have been drawn & provide results:
_____

☐ Ensure patient has taken & prescribed an anti-viral:
☐ Acyclovir 400mg _____

☐ Home medications: ☐ Zyrtec 10mg / ☐ Hydroxyzine 50mg /
☐ Zantac 150mg / Pepcid 20mg (Staff to verify patient has taken.)

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Verify patient & provider are enrolled/authorized in REMS.
☐ Ensure REMS authorization call has occurred prior to infusion.
☐ Provide patient with What You Need to Know about Lemtrada Treatment and Infusion Reactions: A Patient Guide
☐ Complete & submit LEMTRADA REMS Infusion Checklist upon completion of each treatment cycle.

LABORATORY ORDERS

☐ CBC with differential on days: _____
☐ CMP on days: _____
☐ Other: _____

PRE-MEDICATION ORDERS (REQUIRED)

☐ acetaminophen (Tylenol) 1000mg PO each day
☐ diphenhydramine (Benadryl) 50mg PO each day
☐ methylprednisolone (Solu-Medrol) 1000mg IV mixed in 100ml 0.9% NS over 1 hour on days 1, 2, 3 of each cycle treatment

*Unless contraindicated, the above will be given with each treatment cycle.

PRE-MEDICATION ORDERS (ADDITIONAL)

☐ Ibuprofen (Advil) 400mg PO (If indicated, acetaminophen will be held)
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ ranitidine (Zantac) 150mg PO
☐ Methylprednisolone (Solu-Medrol) _____ mg IV mixed in _____ ml NS over 1 hour on days: _____
☐ dexamethasone 80mg IV mixed in 100ml NS over 1 hour on days:
_____
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Alemtuzumab** (Lemtrada) year one
- ☐ Dose & Route: 12mg intravenous infusion
- ☐ Frequency: daily for 5 days
- ☐ Mix in 100ml 0.9% sodium chloride, infuse over four hours (protect from light)
- ☐ Flush with 0.9% sodium chloride at the completion of infusion (infuse at same rate as Lemtrada)
- ☐ Patient required to stay for 120-minute observation

☐ **Alemtuzumab** (Lemtrada) year two/subsequent frequent course
- ☐ Dose & Route: 12mg intravenous infusion
- ☐ Frequency: daily for 3 days
- ☐ Mix in 100ml 0.9% sodium chloride, infuse over four hours (protect from light)
- ☐ Flush with 0.9% sodium chloride at the completion of infusion (infuse at same rate as Lemtrada)
- ☐ Patient required to stay for 120-min observation period

Ordering Provider: Initial here _____ and proceed to the next page.

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK

adaptIV infusion

PRN MEDICATIONS (GIVEN BASED ON PATIENT ASSESSMENT)

☐ acetaminophen (Tylenol) 650mg PO every 6 hours for **mild** pain or fever (alternate with ibuprofen)
☐ ibuprofen (Advil) 400mg PO every 4 hours for **mild** pain or fever (alternate with acetaminophen)
☐ ketorolac (Toradol) 30mg SIVP x 1 for **moderate to severe** pain/headache (Do not give with elevated creatinine. If pain/headache not relieved 15-20 minutes after administration notify provider. Consider stopping infusion and transfer to an acute care setting.)
☐ diphenhydramine (Benadryl) 25-50mg PO every 4 hours for **mild** itching or hives
☐ hydroxyzine 50mg PO every 12 hours for **mild** itching or hives (consider if diphenhydramine already given)
☐ diphenhydramine 25-50mg SIVP, for **severe** itching, rash, or shortness of breath. May repeat 25-50mg SIVP x 1
☐ ondansetron (Zofran) 4mg SIVP every 4-6 hours for nausea/vomiting, may repeat 4mg SIVP x1 for a max dose of 8mg

HYPERTENSION MANAGEMENT

SBP > 30mmhg above baseline or SBP > or = 160
☐ clonidine 0.1mg PO x 1
SBP > 40mmhg above baseline or BP > or = 170/100 Notify provider and repeat VS q 5 minutes
☐ hydralazine 10mg SIVP over 2-3 minutes, may repeat dose x 1 in 20 minutes (Do not give if heart rate >100 BPM)

SPECIAL INSTRUCTIONS

INFUSION/MONITORING PARAMETERS

☐ If any of the following below are present, stop infusion, monitor vital signs every 5 minutes and notify provider.
☐ If blood pressure remains >40mmhg above baseline or ≥ 170/100 after administration of PRN medications.
☐ If chest pain, pressure or tightness that is not relieved with PRN medication administration.
☐ If heart rate < 50 or > 110 and patient symptomatic; dizziness, shortness of breath, chest pain, pressure or discomfort.
☐ If SPO2 < 92% with or without supplemental oxygen.
☐ Any sudden onset or change in neurological symptoms.

* Premedicate patients with high dose corticosteroids (1,000 mg methylprednisolone or equivalent) immediately prior to LEMTRADA infusion and for the first 3 days of each treatment course.

* Administer anti-viral prophylaxis for herpetic viral infections starting on the first day of each treatment course and continue for a minimum of two months following treatment with LEMTRADA or until the CD4+ lymphocytecount is at least 200 cells per microliter, whichever occurs later.

* Observe patients for infusion reactions during and for at least 2 hours after each LEMTRADA infusion.

* Conduct the following laboratory tests at baseline and at periodic intervals until 48 months after the last treatment course of LEMTRADA in order to monitor for early signs of potentially serious adverse effects:
  - Complete blood count (CBC) with differential (prior to treatmentinitiation and at monthly intervals thereafter)
  - Serum creatinine levels (prior to treatment initiation and at monthly intervals thereafter)
  - Urinalysis with urine cell counts (prior to treatment initiation and at monthly intervals thereafter)
  - A test of thyroid function, such as thyroid stimulating hormone(TSH) level (prior to treatment initiation and every 3 months thereafter)
  - Serum transaminases (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin levels (prior to treatment initiation and periodically thereafter)

*** Providers choosing to refer patients for Lemtrada infusions must complete this order set. Outside order sets will not be accepted. Please direct any questions or comments regarding the use of this order set to Matt Munden, RN Director of Nursing or Andrew Lasher, MD Chief Medical Officer.**

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____

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

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK