Lemtrada Enrollment Form

Date: _____
Patient Name: _____
Date of Birth: _____

Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

CVC CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____	☐ Physician's Office
Next Infusion Date: _____	☐ TwelveStone Infusion Center
	☐ TwelveStone Home Infusion
	☐ Other: _____
	Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Multiple Sclerosis	☐ G35

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form
☐ History and Physical
☐ Patient Demographics and Insurance Information
☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: _____ Kg Height: _____ Inches/CM BSA : _____ Allergies: _____

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size_____Gauge_____Length) ☐ Sub-Q

MEDICATION	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (check for TwelveStone to draw)
☐ Lemtrada	12mg Vial	☐ Initiation – Infuse 12mg IV over 4 hours daily x 5 days ☐ Follow Up Dose – (12 months after initial dose) – Infuse 12mg IV over 4 hours daily x 3 days		☐ TSH ☐ Serum Transaminase ☐ Urinalysis w/Urine cell count ☐ Urine Protein to Creatinine Ratio ☐ Varicella Zoster Virus Antibodies ☐ Baseline Skin Exam ☐ Tb QuantiFERON Gold Test

LAB ORDERS - to be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Other_____	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____

PRE-MEDICATIONS

Oral	IV
*Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 4mg ☐ 8mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
*Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	*Methylprednisolone: ☐ _____mg IV over _____ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratidine: ☐ 10mg	
Ondansetron: ☐ 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date