PARAGON HEALTHCARE
A Carelon Company

LEMTRADA (ALEMTUZUMAB) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis/ICD-10:

☐ Relapsing-remitting MS (G35.A)
☐ Primary progressive MS, unspecified (G35.B0)
☐ Primary progressive MS, active (G35.B1)
☐ Primary progressive MS, non-active (G35.B2)
☐ Secondary progressive MS, unspecified (G35.C0)
☐ Secondary progressive MS, active (G35.C1)
☐ Secondary progressive MS, non-active (G35.C2)
☐ MS, unspecified (G35.D)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Lemtrada

☐ **First Course:** 12mg IV daily for 5 consecutive days

☐ **Subsequent Course(s):** 12mg IV daily for 3 consecutive days, 12 months after previous dose

Protocol Pre-Medication Order: Solu-Medrol 1 gram IV on days 1-3 of each course, Tylenol 1000mg PO, Benadryl 25mg IV, and Pepcid 20mg IV prior to infusion.

Other pre-medication orders: _____

Post-Infusion Hydration: ☐ 500mL NS IV post Lemtrada infusion to run over two hours
☐ Other: _____

Lab Orders: _____ **Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR LEMTRADA (ALEMTUZUMAB) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of 2 or more drugs indicated for MS? ☐ Yes ☐ No
    If yes, which drug(s)? _____
  - ☐ Expanded Disability Status Scale (EDSS) score (if available): _____
- ☐ Labs/tests supporting primary diagnosis attached
  - ☐ MRI
- ☐ REMs enrollment paperwork and Prescription Order Form (faxed to MS One to One)
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **TB screening test completed within 12 months - attach results**
  ☐ **Positive** ☐ **Negative**
- ☐ **Required Labs: TSH, Cr, CBC, Ua with cell counts (within 30 days), and AST, ALT, total bilirubin (within 3 months)**
- ☐ **Recommended labs: HIV, Varicella Zoster Antibodies**

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance