BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/____

Date of Last Infusion: ___/___/____ Height_____ Weight_____

Infusion Location: (state and site) _____

Lemtrada® (alemtuzumab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____Multiple Sclerosis _____

(ICD-10) (ICD-10)

Nursing Orders:

- Prior to *first* appointment:
  - Provide and review Lemtrada Patient Guide and obtain CBC, CMP, Thyroid, LFTs, Total bilirubin and TB test, urine cell count and urine protein clearance ration
  - Hold infusion and notify provider for fever or signs/symptoms of illness or active infection or live vaccines
- Prior to *every* appointment:
  - Hold infusion /notify provider if patient reports signs or symptoms of illness or active infection, or signs of stroke or live vaccine
  - Monitor labs listed above at least every 12 months
  - Confirm patient understands and complies with home pre-medication regimen as prescribed (anti-viral herpes prophylaxis, H1/ H2 blockers)
- Monitor vital signs 15 minutes after infusion begins, then at least every hour during infusion
- If infusion-related reaction occurs, stop infusion, and initiate Hypersensitivity Reaction Management Policy/Protocol
- Complete a Lemtrada REMS Infusion Checklist on the last day of each treatment course

Pre-Medications:

- ☐ Tylenol 500 mg PO; may repeat once during infusion PRN headache, myalgia
- ☐ Benadryl 25 or 50 mg IV (circle dose)
- ☐ Solu-Medrol 1000 mg in 100 ml NS, infused over 15-30 minutes immediately *prior to first 3 infusions*
- ☐ Other: _____

☐ Initial Course

Administer Lemtrada 12 mg in 100 ml 0.9% sodium chloride over 4 hours. Repeat daily for

5 consecutive days.

☐ Subsequent Course

Administer Lemtrada 12 mg in 100 ml 0.9% sodium chloride over 4 hours. Repeat daily for

3 consecutive days.

Observation Period:

- Monitor patient for hypersensitivity reaction for a period of 2 hours following each infusion
- Record vital signs hourly during observation period and prior to discharge
- Provide and review discharge instructions prior to discharge

Additional Orders:

_____

_____

Provider Name (print)_____ Date:_____

Provider Signature:_____ Time:_____