CURBSIDE
INFUSION SERVICES
www.curbsideinfusion.com

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Office: 281-406-1046

LEMTRADA (alemtuzumab) infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Multiple Sclerosis ☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg IVP
☐ Quzyttir 10mg IVSP over 1-2 min
☐ _____ *(other)*

LEMTRADA ORDERS

DOSAGE

☐ 12mg IV each day for 5 consecutive days
☐ 12mg IV each day for 3 consecutive days - 12 months after first treatment course

PREMEDICATION PER PRESCRIBING INFORMATION

Solu-medrol 1gm IV for days 1-3 of each course

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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