Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

LEMTRADA® (ALAMTUZUMAB) ORDER FORM

(- Required Fields)*

☐ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

☐ **New Referral** ☐ **Order Renewal** ☐ **Medication/Order Change**
☐ **Benefits Verification Only** ☐ **Discontinuation Order**

Locations:

-------Oklahoma-------
☐ Tulsa

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

LEMTRADA ORDER*:

ICD-10*: _____

*(SELECT **ONE** OF THE FOLLOWING)*

☐ First Course: 12mg/day on 5 consecutive days

☐ Maintenance Dosing: 12mg/day on 3 consecutive days every 12 months.

☐ Okay to infuse at Multiple Locations ☐ Okay to Split Infusions

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____

Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

☐ Relapsing Multiple Sclerosis

☐ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics
☐ Insurance Card/Information
☐ Clinical/Progress Notes supporting DX
☐ Current Medication List and H&P
☐ HIV Test Results
☐ Varicella Zoster Antibodies
☐ TB Results (if available)-if positive, need negative chest Xray and negative TSpot

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: ☐ CMP ☐ CBC

☐ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

REVISION DATE- 04/2020