



Lemtrada Order Form

Select patient referral location: ☐ Akron ☐ Blue Ash ☐ Cleveland ☐ Columbus ☐ Crestview Hills ☐ Springfield ☐ West Cincinnati
☐ Other _____

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg
Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

☐ Multiple Sclerosis ☐ ICD 10 (_____) ☐ Other (specify): _____ Ensure patient has taken & prescribed anti-viral: Acyclovir 400 mg

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

LEMTRADA

- ☐ Initial (Year One)
☐ Administer 12 mg daily for 5 days IV

- ☐ Maintenance (Year Two/Subsequent Frequent Course)
☐ Administer 12 mg daily for 3 days

- ☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other: _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Prednisone _____ mg PO
☐ Other: _____

6. LABS

- | | | |
|--|--|---|
| ☐ CBC w/Diff | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ CRP | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ CMP | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ ESR | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ Hepatic Panel | ☐ each infusion | ☐ Other frequency (specify): _____ |
| ☐ Renal Panel | ☐ each infusion | ☐ Other frequency (specify): _____ |
- ☐ Quantiferon TB Gold, annually, last completed (date): _____
☐ Other (specify): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE