

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183

☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970

☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801

☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788

☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348

☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485

☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418

☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917

☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

**OUTPATIENT ALEMTUZUMAB (LEMTRADA)
ORDERS**

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Diagnosis: _____ **ICD10:** _____

REMS ID #: _____

Varicella Immunity: ☐ Yes ☐ No Date of Vaccination: _____

IV Access:

- ☐ Saline Lock:
- ☒ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
 - ☒ Discontinue Saline Lock after therapy completed
- ☐ PICC Line:
- ☒ Routine PICC Line Care, labs and restoration
 - ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
- ☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☒ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Labwork:

Labs: _____ **Frequency:** _____

Premedication:

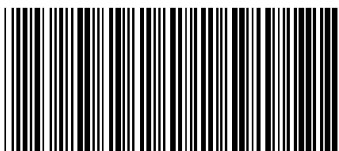
- ☒ Acetaminophen (Tylenol) 650 mg, PO, ONCE
- ☒ Cetirizine (Zyrtec) 10 mg, PO, ONCE
- ☒ Methylprednisolone (Solu-Medrol) 1 gm IVPB, Comments: Day 1, 2, 3 of each course
- ☐ Methylprednisolone (Solu-Medrol) 500 mg IVPB, Comments: Day 4, 5 of first course

Medication:

- ☐ Alemtuzumab (Lemtrada) 12 mg/100 mL Sodium Chloride 0.9%, IVPB, Daily, Infuse over 4 hours , Duration 5 Days
- ☐ Alemtuzumab (Lemtrada) 12 mg/100 mL Sodium Chloride 0.9%, IVPB, Daily, Infuse over 4 hours , Duration 3 Days

*****Patient should have antiviral therapy prescribed to start on Day 1 of Alemtuzumab (Lemtrada) - to take X 4 months**

Other: _____



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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
June 2024 -Header updated and removed reference to Policies