



INFUSION SUITE		LEMTRADA INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		DOB:	
MEDICAL INFORMATION			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
REQUIRED TESTING			
CMP: _____ CBC w. Diff: _____ UA w. CR: _____ TSH: _____ LFT's: _____			
ECG: _____ TB: _____			
Additional labs:			
<input type="checkbox"/> Insert IV	<input type="checkbox"/> Access Port/PICC		
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Ibuprofen:	<input type="checkbox"/> 400mg PO X1		
<input type="checkbox"/> Acthar Gel:	<input type="checkbox"/> 1mg subcutaneous every day X 5 days beginning 2 days before 1st infusion *Steroid allergy		
<input type="checkbox"/> Albuterol Inhaler:	<input type="checkbox"/> 5mg/ml PRN for bronchospasm		
<input type="checkbox"/> Antiemetic	<input type="checkbox"/> Zofran 4mg IV X 1 <input type="checkbox"/> Zofran 4mg ODT X 1		
<input type="checkbox"/> Additional PRN:			
<input type="checkbox"/> Additional PRN:			
<input type="checkbox"/> Additional PRN:			
LEMTRADA ORDERS			
<input type="checkbox"/> Initial:	12mg IV in 100mL NS over 4 hours daily X 5 days		
<input type="checkbox"/> Subsequent:	12mg IV in 100mL NS over 4 hours daily X 3 days - 1 year from last treatment		
POST INFUSION			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Monitor patient for at least 2 hours post infusion			
<input type="checkbox"/> Discharge home		<input type="checkbox"/> May keep IV/Port for successive treatments	
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

***Credentials must be included**

Infusion Directions:

- Withdraw 1.2mL of Lemtrada from the vial in 100mL NS, gently invert bag to mix
- Cover the IV solution bag to protect from light and infuse over 4 hours; no filter required for tubing

Nursing Consideratons:

- Confirm patient, provider, and facility are enrolled in REMs program
- Confirm patient is up to date on current vaccines and that patient is vaccinated or immune to varicella zoster virus.
- Confirm patient has been started on antiviral prophylaxis for herpetic viral infections