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LEMTRADA (alantuzumab) Infusion orders

Name: _____

DOB: _____

M F

Phone #1 : _____ (H/W/C)

Phone #2: _____ (H/W/C)

Diagnosis: Please provide ICD-10 code

_____ Multiple Sclerosis

_____ (other)

PRE-MEDICATION

- Tylenol 1000mg PO
- Diphenhydramine 25mg PO
- Cetirizine 10mg PO
- _____
(other)

- Solu-Medrol 125mg IVP
- Solu-Cortef 100mg IVP
- Diphenhydramine 25mg IVP
- _____
(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 _____

Please FAX: Medication Order Demographics Clinicals Labs X-Rays
to 1-806-302-1241 (must dial "1")