LEMTRADA (ALAMTUZUMAB) Referral FAX (855) 891-2191

Effective: 07/2017

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191 Email: MPPReferral@mppinfusion.com

___ Denver ___ Dallas ___ Duncanville ___ Southlake

___ New Referral ___ Restart ___ Medication/Order Change *(New Order Required)* ___ Benefits Verification Only ___ D/C Infusions **indicate name of drug(s)* ____________

PATIENT INFORMATION

Name: ____________ Date: ________

DOB: ____________ SS# ____________

Phone # ____________

Email: ____________

PHYSICIAN INFORMATION

Referring Physician: ____________

Practice Name: ____________

Specialty: ____________

Office Contact: ____________

Contact Phone # ________ Contact Fax # ________

Contact Email: ____________

LEMTRADA MEDICATION ORDERS

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

___ Second course: 12mg/day on 3 consecutive days 12 months

INDICATION/DIAGNOSIS

___Multiple Sclerosis

___RRMS (Remitting/Relapsing MS)

***ICD-10 ____________ required**

NOTES (ADDITIONAL INFO)

____________ ________

Referring Physician's Signature Date *valid for one year

_____Okay with Separate Locations

_____Okay with Split Infusion

STANDING LAB ORDERS

Labs to be drawn by:

___ Referring Physician

___ Infusion Center

Orders:

Frequency:

REQUIRED DOCUMENTATION

___Recent Office notes (along w/ any therapies tried and outcomes) ___Current Medication List ___History and Physical Report

___ Lab Results ___Insurance Cards (front and back) ___ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

___ TB Results if available

APPOINTMENT DATE & TIME: ____________

FOR OFFICE USE ONLY