

BEAUMONT INFUSION CENTERS

NEUROLOGY PRESCRIPTION

Location / Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Fax Number Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

Patient Name:	Date of Birth:	Medical Record #:
Physician Name:	Physician Address:	Physician Office #:
Diagnosis:		Diagnosis Code (ICD-10):

Please attach these required documents to Prescription (if not in EPIC):
 Copy of Insurance Card Labs Supporting clinical documentation Patient Demographics
 NKDA Drug Allergies: _____
 Height: _____ Weight: _____ kg/lbs Date: _____

Ocrelizumab: Hepatitis B screening completed and patient is clear to receive treatment Yes No

CBC w/ Diff, UA, TSH, Serum Creatinine REQUIRED within One Month of Infusion for Alemtuzumab (Lemtrada)

MEDICATION	DOSE	# Doses
ALEMTUZUMAB (LEMTRADA)	<input type="checkbox"/> Cycle One: 12 mg in 100 mL NS to infuse daily IV over 4 hours for 5 days <input type="checkbox"/> Cycle Two: 12 mg in 100 mL NS to infuse daily IV over 4 hours for 3 days Pre Medications: <ul style="list-style-type: none"> <input type="checkbox"/> Diphenhydramine 50mg IVP daily ½ hour prior to infusion. <input type="checkbox"/> Methylprednisolone 1000 mg IV over one hour prior to infusion for first 3 days of treatment <input type="checkbox"/> Methylprednisolone 500 mg IV over ½ hour prior to infusion on Day 4 of treatment <input type="checkbox"/> Methylprednisolone 250 mg IV over ½ hour prior to infusion on Day 5 of treatment <input type="checkbox"/> Loratadine 10 mg PO daily prior to each infusion. <input type="checkbox"/> Famotidine 20 mg IV push daily prior to each infusion. <input type="checkbox"/> Acetaminophen 1000 mg PO ½ hour prior to each infusion. Other Meds During Infusion: <ul style="list-style-type: none"> <input type="checkbox"/> Acetaminophen 1000 mg PO q4h PRN for flushing <input type="checkbox"/> Ibuprofen 600mg PO q6h PRN for pyrexia, headache (alternate with acetaminophen) <input type="checkbox"/> Diphenhydramine 25 mg IV push q6h PRN for minor itching, or rash <input type="checkbox"/> Ondansetron 8 mg PO q4h PRN for nausea 	
METHYLPREDNISOLONE (SOLUMEDROL)	<input type="checkbox"/> 250mg OR <input type="checkbox"/> 500mg over 30 minutes <input type="checkbox"/> 1gm OR <input type="checkbox"/> 2 gm over one hour IV every 24 hours x _____ Days	
NATALIZUMAB (TYSABRI)	<input type="checkbox"/> 300 mg in 100 ml NS over 60 minutes IV every 28 days (monthly). For the first 12 doses observe for one hour post infusion.	
OCRELIZUMAB (OCREVUS)	<input type="checkbox"/> Initial Dosing: 300 mg in 250 ml NS IV infusion every two weeks x 2 doses Start infusion at 30 ml/hr. Increase by 30 ml/hr every 30 minutes up to a maximum of 180 ml/hr. <input type="checkbox"/> Maintenance Dosing: 600 mg in 500 ml NS IV infusion every 6 months for 1 year (To start 6 months from initial first dose) Start infusion at 40 ml/hr. Increase by 40 ml/hr every 30 minutes up to a maximum of 200 ml/hr. If no previous serious infusion reactions infusion can start at 100 mL/hr for the first 15 minutes; increase to 200 mL/hr for the next 15 minutes; increase to 250 mL/hr for the next 30 minutes; increase to 300 mL/hr for the remaining 60 minutes. Pre Medications: <ul style="list-style-type: none"> <input type="checkbox"/> Diphenhydramine 50mg IVP daily ½ hour prior to infusion. <input type="checkbox"/> Methylprednisolone 100 mg IV ½ hour prior to infusion. <input type="checkbox"/> Acetaminophen 650 mg PO ½ hour prior to infusion. <ul style="list-style-type: none"> • Observation for at least one hour after the completion of the infusion. 	
	<ul style="list-style-type: none"> • 250 ml 0.9% Sodium Chloride flush bag with infusion as needed. • Adult Anaphylaxis Protocol. Notify physician if reaction occurs. 	

Physician Signature _____ Beeper # _____ Date _____ Time _____