Leqembi

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs: MRI within 1 year of initiating treatment AND prior to the 3rd, 5th , 7th and 14th infusions

☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

☐ Patient's Registry Trial Number: _____

Click link to access registry: qualitynet.cms.gov/alzheimers-ced-registry/submission

ICD-10 CODE

☐ Z00.6 (noting a registry-must be done for every patient) AND select one of the following:

☐ G30.0 Alzheimer's disease with early onset ☐ G30.1 Alzheimer's disease with late onset ☐ G30.8 Other Alzheimer's disease

☐ G31.84 mild cognitive impairment, so stated ☐ G30.9 Alzheimer's disease, unspecified ☐ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO **Diphenhydramine** (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Cetirizine (Zyrtec) ☐ 10mg PO **Methylprednisolone** (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Loratadine (Claritin) ☐ 10mg PO **Hydrocortisone** (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Leqembi (lecanemab-irmb)

Dose:

☐ 10mg/kg IV

Frequency:

☐ Every 2 weeks

☐ Every 4 weeks (after 18 months of treatment)

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

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