

Leqembi

Lecanemab



Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order: Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing (Cognitive Screening, Amyloid Beta Pathology on Pet/LP, Recent Brain MRI); Most Recent Office Visit Note, CMS Registry Number, Clinical Trial Number

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): G30.0 G30.1 G30.8 G30.9 G31.84 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- Results of follow-up MRIs will be required PRIOR to administering the 3rd, 5th, 7th, and 14th infusions.
- CMS Registry Number: ALZH _____
- MoCA (or other cognitive test) score _____
- FAQ (or other functional test) score _____

THERAPY ADMINISTRATION

- Leqembi Intravenous Infusion
Dose: 10mg/kg
Frequency: Every 2 weeks / Every 4 weeks
After 18 months of therapy, re-evaluate frequency and continue treatment once every 2 weeks or once every 4 weeks.
 - Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)
- To ensure that a brand name product is dispensed, the prescriber must handwritten "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.*

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

- Diphenhydramine 25mg / 50mg PO / IV
- Acetaminophen 325mg / 500mg / 650mg PO
- Methylprednisolone 40mg / 125mg IV
- Other: _____
Dose: _____ Route: _____ Frequency: _____

_____	_____	_____
Provider Name (Print)	Provider Signature	Date

- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.