

LEQEMBI ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

- a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
- b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PLEASE SELECT FROM BELOW:

- Perform port flush every _____ weeks per hospital policy.
- Perform IV site care per hospital protocol.
- Activase 2mg IVP per hospital protocol.

DUAL DIAGNOSIS IS REQUIRED – SELECT ONE OPTION OF BOTH CONDITIONS THAT APPLY FROM BELOW:

- G30.0 Alzheimer's Disease, Early Onset
 - G30.1 Alzheimer's Disease, Late Onset
 - G30.8 Other Alzheimer's disease
 - G30.9 Alzheimer's disease, unspecified
 - G31.84 Mild Cognitive Impairment, So Stated
 - Other: _____ (ICD 10 + Description)
- ← G30.X codes require secondary F02.8X code →
- F02.80 Dementia without behavioral disturbance
 - F02.81 Dementia with behavioral disturbance

Prescriber must indicate the following requirements have been met (please provide documentation):

- Beta Amyloid Pathology Confirmed Via
- Amyloid PET Scan Date: _____ OR CSF Analysis Date: _____ Result: _____
- Cognitive Assessment Used: _____ Date: _____ Result: _____
- ApoE ε4 Genetic Test Date: _____ Result: Homozygote Heterozygote Noncarrier

PRESCRIPTION ORDERS

Leqembi	10 mg/kg	IV Over At Least 60 Minutes	Every 2 Weeks <i>(at least 14 days apart)</i>	12 Months
DRUG	DOSE	ROUTE	FREQUENCY	DURATION

Pre-Infusion:

- Confirm baseline MRI results prior to initiation of treatment.
- Confirm MRI completed and reviewed by prescriber prior to the 5th, 7th, and 14th treatment.
- Measure and record weight prior to each treatment to determine dose.
- Hold infusion and notify provider if patient reports:**
 - Headache.
 - Dizziness.
 - Nausea.
 - Vision changes.
 - New or worsening confusion.

Post-Infusion:

- Educate patient/caregiver to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.