Local Infusion

MYLOCALINFUSION.COM

LEQEMBI (LECANEMAB-IRMB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____ APoE4 Status: _____

DIAGNOSIS (Provider must specify)

- ❑ Alzheimer's disease w/early onset: G30.0
- ❑ Alzheimer's disease w/late onset: G30.1
- ❑ Alzheimer's Disease, unspecified: G30.9
- ❑ Mild Cognitive Impairment: G31.84
- ❑ Other Alzheimer's Disease: G30.8 _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

- ❑ Acetaminophen (Tylenol) 500 mg PO
- ❑ Benadryl 25mg PO
- ❑ Famotidine 20 mg IV
- ❑ Cetirizine (Zyrtec) 10 mg PO
- ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Leqembi	❑ 10 mg/kg	❑ IV	❑ Every 2 weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: _____