Local Infusion

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# LEQEMBI (LECANEMAB-IRMB) ORDER FORM

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

CMS Registry #_____(Medicare only)

ALZ-Net #_____(All other commercial payors/approved alz-net providers only)

❑ Patient has known difficult venous access. Comments:_____

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

## 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 |
|---|---|---|---|
| **Loading Dose** | 10 mg/kg | IV | ❑ Every 2 weeks for 12 months |
| **Maintenance Dose** | 10 mg/kg | IV | Every 2 weeks for remaining 6 months and then:<br>❑ Every 2 weeks ❑ Every 4 weeks |

**ORDER DURATION: Maximum 12 months from the date of provider signature. A new signed order is required for continued treatment beyond 12 months, regardless of loading or maintenance phase.**

## LABS / SPECIAL INSTRUCTIONS