

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Leqembi (lecanemab-irmb)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose/Frequency Change	<input type="checkbox"/> Order Renewal

Location Preference (optional)	
<input type="checkbox"/> Richmond	<input type="checkbox"/> Prince George

** If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required **

DIAGNOSIS AND ICD-10 CODE			
<input type="checkbox"/> Alzheimer's disease w/ early onset	G30.0	<input type="checkbox"/> Alzheimer's disease w/ late onset	G30.1
<input type="checkbox"/> Other Alzheimer's disease	G30.8	<input type="checkbox"/> Alzheimer's disease, unspecified	G30.9
<input type="checkbox"/> Mild Cognitive Impairment, so stated	G31.84		
<input checked="" type="checkbox"/> REQUIRED SECONDARY: Encounter for exam for normal comparison and control in clinical research program			Z00.6
<input type="checkbox"/> Other:	ICD10		

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> Current Medication List	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Most recent MRI results	
<input type="checkbox"/> Confirm patient is NOT on any anticoagulant medication	
<input type="checkbox"/> Documentation of positive biomarker for beta amyloid plaques (such as PET scan and/or CSF testing)	
<input type="checkbox"/> Genotype testing for ApoE status	
<input type="checkbox"/> Documentation of <u>cognitive impairment</u> with the Montreal Cognitive Assessment (MoCA) or other assessment	
<input type="checkbox"/> Documentation of <u>functional abilities</u> with the Functional Activities Questionnaire (FAQ) or other assessment	
<input type="checkbox"/> If available, the Clinical Dementia Rating (CDR) results	
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____

MEDICATION ORDERS**	
Dosing:	<input checked="" type="checkbox"/> Leqembi 10 mg/kg infuse IV over 1 hour every 2 weeks
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in
Duration: _____ <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____	
<input type="checkbox"/> By checking this box, ordering prescriber agrees to monitor the patient according to the Leqembi package insert with follow-up MRIs to the patient's treatment of the 5 th , 7 th , and 14 th doses. MUST provide results prior to 5 th , 7 th , and 14 th doses to Infusion Solutions.	

**For all weight-based therapies, Infusion Solutions will obtain/verify a patient's current weight.

OPTIONAL PREMEDICATIONS and LAB ORDERS	
<input type="checkbox"/> Acetaminophen 650 mg PO prior to infusion	
<input type="checkbox"/> Diphenhydramine 25 mg PO or IV (per patient preference) prior to infusion	
<input type="checkbox"/> Methylprednisolone 40 mg slow IVP prior to infusion	
<input type="checkbox"/> Other PreMed or Lab Order with frequency: _____	

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:	Date:		

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.