

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**REFERRAL STATUS**

New Referral       Dose or Frequency Change       Order Renewal

**DIAGNOSIS AND ICD-10 CODE**

<input type="checkbox"/> G30.0 Alzheimer's disease with early onset	<b>SECONDARY DIAGNOSIS CODE</b>
<input type="checkbox"/> G31.84 Mild Cognitive Impairment due to Alzheimer's Disease	<input type="checkbox"/> F02.80 Dementia without behavioral disturbance
<input type="checkbox"/> G30.1 Alzheimer's disease late onset	<input type="checkbox"/> F02.81 Dementia with behavioral disturbance
<input type="checkbox"/> G30.8 Other Alzheimer's disease	
<input type="checkbox"/> G30.9 Alzheimer's disease, unspecified	

**REQUIRED DOCUMENTATION**

This signed order form by the provider       Patient demographics AND insurance information  
 H&P and Clinical/Progress notes supporting primary diagnosis       MEDICARE REGISTRATION # (if applicable) \_\_\_\_\_  
 Beta Amyloid Pathology Confirmed via: \_\_\_\_\_  
 Amyloid PET Scan    OR     CFS Analysis - Date: \_\_\_\_\_ Result: \_\_\_\_\_  
 Cognitive Assessment Used: \_\_\_\_\_ Date: \_\_\_\_\_ Result: \_\_\_\_\_  
 ApoE εε4 Genetic Test - Date: \_\_\_\_\_ Result:  Homozygote     Heterozygote     Noncarrier

**MEDICATION ORDERS**
**Leqembi 10mg/kg IV over one hour**

Frequency (Only one stage of treatment may be ordered at a time)	MRI Requirements	Results (must be cleared by ordering provider)
<input type="checkbox"/> Stage 1 (Infusions 1-4): every two weeks x 4 doses	MRI within one year prior to initial infusion	MRI Date: _____ Cleared: Yes <input type="checkbox"/> or No <input type="checkbox"/>
<input type="checkbox"/> Stage 2 (Infusions 5-6): every two weeks x 2 doses	MRI prior to dose #5	MRI Date: _____ Cleared: Yes <input type="checkbox"/> or No <input type="checkbox"/>
<input type="checkbox"/> Stage 3 (Infusions 7-13): every two weeks x 7 doses	MRI prior to dose #7	MRI Date: _____ Cleared: Yes <input type="checkbox"/> or No <input type="checkbox"/>
<input type="checkbox"/> Stage 4 (Infusions 14 and beyond): every two weeks x _____ doses	MRI prior to dose #14	MRI Date: _____ Cleared: Yes <input type="checkbox"/> or No <input type="checkbox"/>
<input type="checkbox"/> >18 months of treatment: every _____ weeks x _____ doses	MRI frequency per provider	MRI Date: _____ Cleared: Yes <input type="checkbox"/> or No <input type="checkbox"/>

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline  
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration  
 RN to flush and lock VAD/CVAD per company protocol  
 Other: \_\_\_\_\_

**PREMEDICATION ORDERS**

Acetaminophen 650mg PO prior to infusion       Other: \_\_\_\_\_  
 Diphenhydramine 25mg PO prior to infusion       Other: \_\_\_\_\_

**EMERGENCY MEDICATIONS**

Administer the following medications as needed for infusion-related reactions per company protocol:

**Adults (weight >40kg):**

Diphenhydramine 25mg-50mg PO  
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins  
 Acetaminophen 325mg-650mg PO  
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.3mg IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive  
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

**Pediatrics (weight <40kg): (may adjust with weight changes)**

Diphenhydramine 25mg PO  
 Diphenhydramine 25mg slow IV push over 2-5 mins  
 Acetaminophen 325mg PO  
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_