

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	SECONDARY DIAGNOSIS CODE
<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: _____