

LEQEMBI

(lecanemab-irmb)

FLEXCARE
INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
 - History & Physical
 - Patient Demographics
 - Medication List
 - Tried/Failed Therapies
 - Most Recent Labs
 - MRI within 1 year
 - Amyloid Pathology Confirmation
 - Cognitive Assessment & Score
 - Functional Assessment & Score
- Registry # _____

PRIMARY AND SECONDARY DIAGNOSIS

Primary Diagnosis

- ☒ Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis

- ☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.9 Alzheimer's disease, unspecified
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- ☒ Per infusion clinic protocol: Acetaminophen 650mg, cetirizine or loratadine 10mg PO before each dose
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI after 1, 2, 3, and 6 months of treatment.

- ☐ Leqembi 10mg/kg (_____mg) IV every 2 weeks
☐ Leqembi 10mg/kg (_____mg) IV every 4 weeks (optional dosing after 18 months)
☐ Other: _____

First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy) ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

REVISED 8/26