immersiv HEALTH

LEQEMBI® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.8 Other Alzheimer's disease
☐ G30.9 Alzheimer's disease, unspecified
☐ G31.84 Mild cognitive impairment, so stated

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information
☐ List of Medications
☐ Most Recent History & Physical
☐ Tried & Failed Therapies
☐ Cognitive Assessment & Score
☐ Functional Assessment & Score
☐ Confirmed Amyloid Pathology
☐ Recent MRI prior to initiating LEQEMBI
☐ Proof of CED registry submission

MEDICATION ORDER

***Referring provider responsible for obtaining MRI prior to infusion #5, #7 and #14 for monitoring of ARIA**

☐ Leqembi® (lecanemab) 10mg/kg IV in 250ml NS over 60 minutes every 2 weeks

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

PRE-MEDICATIONS

PO
☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV
☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 30 minutes following each administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN