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 #3, #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

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