INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Leqembi *lecanemab-irmb*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Alzheimer's disease with early onset, ICD 10: G30.0
☐ Alzheimer's disease with late onset, ICD 10: G30.1
☐ Other Alzheimer's disease, ICD 10: G30.8
☐ Alzheimer's disease, unspecified, ICD 10: G30.9
☐ Mild cognitive impairment, ICD 10: G31.84

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Baseline MRI within 1 year
☐ Repeat MRIs needed prior to the 3rd, 5th, 7th and 14th infusion (more frequently if ARIA suspected)
☐ Demographics
☐ Office/progress notes
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Loading Dose	10 mg/kg	IV	☐ Every 2 weeks for 12 months
Maintenance Dose	10 mg/kg	IV	Every 2 weeks for remaining 6 months and then: ☐ Every 2 weeks ☐ Every 4 weeks

ORDER DURATION: Maximum 12 months from the date of provider signature. A new signed order is required for continued treatment beyond 12 months, regardless of loading or maintenance phase.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____