Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Leqembi (Lecanemab-irmb)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

* * If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required * *

DIAGNOSIS AND ICD-10 CODE			
☐ Alzheimer's disease w/ early onset	G30.0	☐ Alzheimer's disease w/ late onset	G30.1
☐ Other Alzheimer's disease	G30.8	☐ Alzheimer's disease, unspecified	G30.9
☐ Mild Cognitive Impairment, so stated	G31.84		
☐ Other Diagnosis:_____		ICD10 _____	

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ Documentation of positive biomarker for beta amyloid plaques (such as PET scan and/or CSF testing)	
☐ Documentation of mild cognitive impairment or mild dementia stage of Alzheimer's with appropriate assessements; for instance the Mini-Mental State Exam (MMSE) or Alzheimer's Disease Assessment Scale (ADAS-Cog 13) or other	
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS**
Dosing ☐ **Leqembi** 10mg/kg infuse IV over 1 hour every 2 weeks
Patient Weight: _____ kg or _____ lb Patient Height: _____ in
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____
Date of last MRI: _____
☐ **By checking this box,** ordering prescriber agrees to monitor the patient according to the package insert of Leqembi with follow-up MRIs prior to the patient's treatment of the **5th**, **7th**, and **14th** doses of Leqembi.

**For all weight-based therapies, Infusion Solutions will obtain/verify a patient's current weight.

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☐ Methylprednisolone 40mg slow IVP
☐ Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.