

Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order:** Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing (Cognitive Screening, Amyloid Beta Pathology on Pet/LP, Recent Brain MRI); Most Recent Office Visit Note, CMS Registry Number, Clinical Trial Number

## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): ☐ G30.0 ☐ G30.1 ☐ G30.8 ☐ G30.9 ☐ G31.84 ICD Description: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## NURSING

- ☒ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☒ Results of follow-up MRIs will be required PRIOR to administering the 3rd, 5th, 7th, and 14th infusions.
- ☐ Check this box if you DO NOT authorize Infusion for Health to interpret MRI results
- ☒ CMS Registry Number: ALZH \_\_\_\_\_  
Clinical Trail Number (8 digits): NCT \_\_\_\_\_  
*All Medicare patients must be enrolled in a qualifying study and will not be scheduled without this information.*

## PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
- ☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV
- ☐ Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

## LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every \_\_\_\_\_
- ☐ CMP ☐ at each dose ☐ every \_\_\_\_\_
- ☐ Other: \_\_\_\_\_ ☐ Frequency: \_\_\_\_\_
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

## THERAPY ADMINISTRATION

- ☒ Leqembi Intravenous Infusion  
Dose: 10mg/kg  
Frequency: ☐ Every 2 weeks / ☐ Every 4 weeks  
*After 18 months of therapy, re-evaluate frequency and continue treatment once every 2 weeks or once every 4 weeks.*
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ \_\_\_\_\_  
(if not indicated order will expire one year from date signed)  
*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

- ☐ Please check this box if you DO NOT authorize Infusion for Health to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.