

# Leqembi Order Form

Fax completed form to: \_\_\_\_\_



PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:	Lic.#:	DEA #:	
Practice Name:	NPI#:		City/State/Zip:
Address:	City/State/Zip:		Phone:
Office Contact:	Phone:		Fax:
Supervisory Physician (if applicable):			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable Baseline and most recent MRI results (within the past year)		Imaging to confirm presence of amyloid beta pathology via MRI or PET scan APOE ε4 Carrier Status Documentation of mild cognitive impairment Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed    Other <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>			
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV infusion as needed	Solu-cortef 250mg-500mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV infusion as needed Other
<b>Pre-Medications:</b> (Check all that apply)	Per prescribing information: Pre-medications of antihistamine, corticosteroid and analgesic is recommended Acetaminophen _____ mg PO _____ minutes prior to infusion    Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion Diphenhydramine _____ mg    PO ---OR--- IV infusion _____ minutes prior to infusion    Other		
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose?	Yes	No	If No, when was last dose given? _____ When is patient due for next dose? _____
Leqembi	10mg/kg IV in 250mL 0.9% Normal Saline    gravity or    pump through a low-protein binding 0.2 micron in-line filter over 1 hour once every 2 weeks <b>Note:</b> Obtain MRI prior to 5 <sup>th</sup> , 7 <sup>th</sup> and 14 <sup>th</sup> infusion. MRI results must be cleared by MD in order to proceed to next infusion.		_____
OTHER			_____
<i>By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</i>			

Prescriber's Signature \_\_\_\_\_  
 Dispense as Written    Print Name    Date

Prescriber's Signature \_\_\_\_\_  
 Substitution Permitted    Print Name    Date

