

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

Mild Alzheimer's Disease Dementia
 Alzheimer's disease with early onset, G30.0
 Alzheimer's disease with late onset, G30.1
 Other Alzheimer's disease, G30.8
 Alzheimer's disease, unspecified, G30.9
Secondary diagnosis For Medicare: must include ICD10 Z00.6

Mild Cognitive Impairment due to Alzheimer's Disease
 Mild cognitive impairment, G31.84

**ICD 10 Code Required*

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Leqembi® (lecanemab-irmb)	_____ mg (10 mg/kg)	Infuse IV over 1 hour once every 2 weeks x 1 year <input type="checkbox"/> Observe patient for 4 hours after infusion 1, for 2 hours after infusions 2-6, and if no reactions for 30 minutes for all subsequent infusions.

Is patient currently receiving therapy above from another facility?
 Yes No
 If yes, Facility Name: _____
 Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

No premeds ordered at this time
 Acetaminophen 650mg PO Diphenhydramine 25mg PO
 Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP
 Other: _____

LAB ORDERS

Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC w/diff and Platelets q _____ CMP q _____
 Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

- The patient has been diagnosed with Alzheimer's disease. Date of clinical diagnosis (required): _____
- The patient has documented mild cognitive impairment or mild dementia stage of Alzheimer's disease.
Please indicate method(s) for assessment and attach copy:
 Montreal Cognitive Assessment (MoCA) Alzheimer's Disease Assessment Scale (ADAS-Cog14)
 Mini-Mental State Exam (MMSE) Other: _____
- The patient's functional abilities have been assessed.
Please indicate method(s) for assessment and attach copy:
 Functional Activities Questionnaire (FAQ) Alzheimer's Disease Cooperative Study – Activities of Daily Living Inventory Scale (ADCS-ADL-MCI)
 Functional Assessment Staging Tool (FAST)
 Other: _____
- A Clinical Dementia Rating-Global Score (CDR-GS) was completed. **Please attach copy of assessment form.**
- The patient has a positive biomarker for beta amyloid plaques.
 Amyloid positron emission tomography (PET) scan Other: _____
 Cerebrospinal fluid (CSF) testing
- The patient has a recent (within one year) brain MRI scan. Date of MRI: _____
***Referring provider is responsible for scheduling and obtaining an MRI prior to the 5th, 7th, and 14th infusions.**
- The patient will not be receiving anticoagulation therapy or antiplatelets while on Leqembi®.
 If currently on anticoagulants or antiplatelets, please specify drug and dose: _____

LAB AND TEST RESULTS (required)

Amyloid PET scan CSF results MRI brain scan Other: _____
 For Medicare patients: confirmation of Alzheimer's CED Registry submission; Registry # _____