

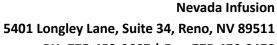


Leqembi Order Form

Patient Nar	me:			DOB:
				Allergies:
DIAGNOSIS	S: neimer's Disease with Earl	y Onset ICD-10: G30.0	☐ Mi	ild Cognitive Impairment ICD-10: G31.84
	neimer's Disease with Late neimer's Disease, Unspeci			her Alzheimer's Disease ICD-10: G30.8
	R LEQEMBI (LECANEMA	•		
	ng/kg IV every 2 weeks	•	+b = 1 = + d = = = = =	ad the continue variet have a duition often the 1st days
-	t will be monitored for 1 i I REGISTRY NUMBER (N			nd the patient must have a driver after the 1st dose.
LLQLIIID		VIEDIO IIIE IIEQUIIEE	-7	
PRE-INFUS	ION REQUIREMENTS:			
		rior to treatment ini	tiation. MRI fi	ndings must be reviewed and approved in
				t, 5th, 7th, 14th infusion, or if the patient
	· .		_	nausea, vision changes, or cognitive changes).
				otoms occur. Patients' weight will need to be
	asured and recorded prior	•		_
PRE-MEDIC	^ATIONS:			
PKL-WILDIC	Acetaminophen 650	∩ma PO		
	☑ Diphenhydramine 2	•	tec 10 mg PO	
	✓ Hydrocortisone 100	•	_	ma IV
	☐ Additional Pre-Med			_
	- Additional Fre-Wed			
MAY ADMI	INISTER IF NEEDED FOR	ALLERGIC REACTION	N:	
✓ Nev	ada Infusion Hypersen	sitivity Reaction Ord	ler Set	
☐ Oth	ier:			
ACCESS: Per	ipheral IV, Port, Midline, o			
	10 mls NS pre/post infusion	on OR Heparin 5ml for	r port – 100 unit	rs/ml
	Per Nevada Infusion		Fox *****	to
TAR2 OKDE	<i>(</i>):		Fax results	to:
	INFORMATION:			
Physician N	lame:			_ NPI:
Physician S	ignature:			_ Date:
UNINT AT I A	nract!	Uhan	10.	-maii:

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

^{**}Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **





PH: 775-453-0667 | Fax: 775-470-8478

Patient Name: DOB:				
Please Include Required Documentation for Expedited Order Processing & Insurance Approval:				
☐ Signed provider orders (page 1)				
☐ Patient demographic and insurance information				
☐ Patient's current medication list				
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)				
\square Supporting documentation to include past tried and/or failed therapies				
\square Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or				
contraindications to conventional therapy				
☐ Please indicate any tried and failed therapies:				
Additional REQUIRED Information:				
\square Patient enrolled in the CMS National Patient Registry (Medicare required)				
Submission reference #:				
https://qualitynet.cms.gov/alzheimers-cedregistry/submission				
☐ Patient enrolled in the Memory Treatment Centers				
MRI Tracker Submission reference #:				
\square Confirmed presence of amyloid pathology (please include results)				
Amyloid PET scan OR +CSF (cerebrospinal fluid)				
☐ MRI of the brain (within 1 year, please include results)				
☐ Cognitive assessment scores (list all available, please include results)				
☐ MMSE: Score Date of assessment:				
☐ MoCA: Score Date of assessment:				
☐ CDR: Score Memory box: Score Date of assessment:				
☐ Other: Score: Date of assessment:				
☐ Functional assessment score: (please include results)				
Name of Assessment: \square FAQ \square FAST \square Other:				
Date of assessment:				
\Box Does the patient have objective impairment in episodic memory as evidenced by a memory test (i.e., Free and				
Cued, Wechsler, etc.)?				
☐ Yes OR ☐ No				
\square Is the patient on therapeutic anticoagulation/antiplatelet therapy?				
☐ Yes OR ☐ No				
If ves, please note therapy and dose:				

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