Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Leqembi Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Alzheimer's Disease with Early Onset ICD-10: G30.0
- ☐ Alzheimer's Disease with Late Onset ICD-10: G30.1
- ☐ Alzheimer's Disease, Unspecified ICD-10: G30.9
- ☐ Mild Cognitive Impairment ICD-10: G31.84
- ☐ Other Alzheimer's Disease ICD-10: G30.8

ORDER FOR LEQEMBI (LECANEMAB-IRMB):

- ☐ **10mg/kg IV every 2 weeks x 1 year.**

***The patient will be monitored for 1 hour observation after the 1st dose, and the patient must have a driver after the 1st dose.
****LEQEMBI REGISTRY NUMBER (MEDICARE REQUIRED):**_____

PRE-INFUSION REQUIREMENTS:

- ☑ **Baseline MRI is required prior to treatment initiation. MRI findings must be reviewed and approved in writing by the ordering provider before administering the 1st, 5th, 7th, 14th infusion,** or if the patient develops symptoms suggestive of ARIA (headache, dizziness, nausea, vision changes, or cognitive changes). Infusions must be held, and the provider notified if such symptoms occur. Patients' weight will need to be measured and recorded prior to each treatment to determine dosage**.**

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

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. **

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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)
☐ Supporting documentation to include past tried and/or failed therapies
☐ 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:

☐ 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 #: _____
☐ 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: ☐ FAQ ☐ FAST ☐ Other: _____
Date of assessment: _____
☐ 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
☐ Is the patient on therapeutic anticoagulation/antiplatelet therapy?
☐ Yes OR ☐ No
If yes, please note therapy and dose: _____

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Revised 04/25