LEQEMBI INFUSION ORDER (LECANEMAB)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight (Required):_____ lbs/kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ G30.0: Alzheimer's disease with early onset
- ☐ G30.1: Alzheimer's Disease with late onset
- ☐ G30.9: Alzheimer's Disease, Unspecified
- ☐ Other : _____

LEQEMBI THERAPY ORDER

- ☐ Leqembi 10mg/kg IV Every 2 weeks
- ☐ Leqembi 10mg/kg IV Every 4 weeks

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994