Provider Order Form

LEQEMBI (LECANEMAB-IRMB)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA APoE4 Status: _____

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Alzheimer's disease w/early onset: G30.0
☐ Alzheimer's disease w/late onset: G30.1
☐ Alzheimer's Disease, unspecified: G30.9
☐ Mild Cognitive Impairment: G31.84
☐ Other Alzheimer's Disease: G30.8 _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ LEQEMBI (LECANEMAB-IRMB) IV in 250 mL of 0.9% Sodium Chloride	☒ 10 mg/kg	☒ Every 2 weeks

☐ Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____
☒ Infuse over 60 minutes.
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

☐ Repeat brain MRI **MUST** be obtained prior to infusion 5, 7 and 14

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ MRI of brain (within past year)
☐ PET scan or CSF results with amyloid beta confirmation ☐ Results of cognitive assessment ☐ Letter of medical necessity
☐ I attest that this patient is enrolled in a Registry or Clinical Trial

Name of Registry or Clinical Trial: _____ NCT#: _____

_____ _____
Provider Signature Date