

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

- ☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Baseline Brain MRI ☐ Cognitive assessment score
☐ Documented evidence of beta-amyloid plaque on the brain (PET, CSF, Lumbar, Blood test)

PATIENT

Full Name:		DOB:	
Mobile Phone:	Height:	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 | ☐ Mild Cognitive Impairment: G31.84 |
| ☐ Alzheimer's disease w/late onset: G30.1 | ☐ Other Alzheimer's Disease: G30.8 |
| ☐ Alzheimer's Disease, unspecified: G30.9 | ☐ Other: _____ |

REGISTRY NUMBER – (required for patients with Medicare)

Registry Number: _____

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 | |
| ☐ Cetirizine (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 for 18 months
		☐ Maintenance: After 18 months, continue treatment once every 2 weeks or
		☐ once every 4 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_____
Provider Signature_____
Date