

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- MRI within 1 year
- CSF or PET scan showing amyloid pathology
- Cognitive assessment & score

PRIMARY DIAGNOSIS

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

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Leqembi

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 5th, 7th, and 14th infusions

- Leqembi 10mg/kg IV (calculated dose _____ mg) every 2 weeks
- Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC
- Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date