SPRINGSIDE INFUSION

Leqembi

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis

☐ Alzheimer's disease with early onset (g30.0)
☐ Alzheimer's disease with late onset (g30.1)
☐ Other alzheimer's disease (g30.8)
☐ Alzheimer's disease, unspecified (g30.9)
☐ Mild cognitive impairment (g31.84)
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications

☐ N/A
☐ Provider prescribed: _____

Medication order

Dose
☐ 10 mg/kg
☐ Other _____

Frequency
☐ Every 2 weeks
☐ Other _____

Medication route

☐ IV
☐ Other _____

Lab order (Include frequency)

Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites

Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Baseline MRI within 1 year | Repeat mris needed prior to the 3rd, 5th, 7th and 14th infusion (more frequently if aria suspected)

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____