Leqembi

(Lecanimab) Infusion Order

NobleInfusion
Phone: 386-957-9600
Fax: 386-957-9400

PATIENT INFORMATION:

Patient Name: _____ ☐ Male ☐ Female
DOB: _____ Phone number: _____
Allergies: ☐ NKDA ☐ allergic to _____
☐ start new treatment ☐ continue treatment. _____ doses have already been completed

Height: _____ Weight:_____

CMS Submission #: _____

DIAGNOSIS:

Fill in IDC-10 Code with diagnosis
☐ MCI due to AD _____ ☐ Mild AD Dementia _____
☐ Other: _____ code: _____

PREMEDICATION:

☐ acetaminophen 1000 mg PO ☐ Diphenhydramine 25 mg PO **OR** Cetirizine 10 mg PO
☐ Solu Medrol 125 mg IVP ☐ Solu-Cortef 100 mg IVP ☐ Diphenhydramine 25 mg IV

REQUIRED TESTING/LABS

*MRI prior to initiating treatment AND prior to 5th, 7th, and 14th infusion
*PET Scan
*Patients last visit note
*Clinical notes with amyloid beta confirmation
*APOe3 testing- optional
*MoCA or MMSE

LEQEMBI DOSING:

☐ 10mg/kg IV every 2 weeks

★ Patient takes anticoagulants and provider has approved Leqembi treatment ☐yes ☐no

★ If yes, has provider discussed risk of ARIA with patient ☐yes ☐no

ORDERING PROVIDER:

Name: _____ NPI _____
Phone: _____ fax: _____
Practice Address: _____
City: _____ State: _____ Zip: _____

Provider Signature_____ Date: _____