Lecanemab-irmb (Leqembi)

Provider Order Form *rev. 11/11/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• MRI within 1 year • Amyloid Pathology Confirmation • Cognitive Assessment & Score • Functional Assessment & Score

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

Primary Diagnosis: ☑ Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis: ☐ G30.0 Alzheimer's disease with early onset ☐ G30.9 Alzheimer's disease, unspecified

☐ G30.1 Alzheimer's disease with late onset ☐ G31.84 Mild cognitive impairment, so stated

☐ G30.8 Other Alzheimer's disease

REQUIRED DOCUMENTATION

Referring providers must register patients with Medicare and Medicare Advantage in the CMS registry and provide proof of registration prior: https://qualitynet.cms.gov/alzheimers-ced-registry/submission

Attach proof of CMS Registry Confirmation or provide below:
Issue Number: ALZH-_____
Date of Submission:_____

☑ **I, the prescribing provider, am responsible for ordering and reviewing all MRIs of the brain for this patient. By checking this box, I acknowledge that I have obtained and reviewed a baseline (within 1 year) MRI and communicated the results to the patient or his/her legal guardian will obtain and review an MRI prior to the 3rd, 5th, 7th and 14th infusion .**

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

PRIMARY MEDICATION ORDER

☑ Referring provider must obtain and review new MRI and provide clearance prior to the 3rd, 5th, 7th and 14th infusion

Lecanemab-irmb (Leqembi), Intravenous Infusion

• Refill for 12 months unless otherwise noted: _____

☐ **Starting dosage:** 10 mg/kg every 2 weeks

☐ **Optional dosage after 18 months on therapy:** 10 mg/kg every 4 weeks

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Leqembi

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772
☐ Arbor Infusion Carmel (317) 981-1772