SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

LEQEMBI ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex : ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PLEASE SELECT FROM BELOW:

☐ Perform port flush every _____ weeks per hospital policy.
☐ Perform IV site care per hospital protocol.
☐ Activase 2mg IVP per hospital protocol.

DUAL DIAGNOSIS IS REQUIRED – SELECT ONE OPTION OF BOTH CONDITIONS THAT APPLY FROM BELOW:

□ G30.0 Alzheimer's Disease, Early Onset
□ G30.1 Alzheimer's Disease, Late Onset
□ G30.8 Other Alzheimer's disease
□ G30.9 Alzheimer's disease, unspecified
□ G31.84 Mild Cognitive Impairment, So Stated
← G30.X codes require secondary F02.8X code →
□ F02.80 Dementia without behavioral disturbance
□ F02.81 Dementia with behavioral disturbance
□ Other:_____ (ICD 10 + Description)

Prescriber must indicate the following requirements have been met (please provide documentation):

□ Beta Amyloid Pathology Confirmed Via

□ Amyloid PET Scan Date:_____ **OR** □ CSF Analysis Date:_____ Result:_____

□ Cognitive Assessment Used:_____ Date:_____ Result:_____

□ ApoE ε4 Genetic Test Date:_____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier

□ CMS Alzheimer National Patient Registry Number: ALZH - _____ □ National Clinical Trial Number: NCT - _____

PRESCRIPTION ORDERS

Leqembi	**10 mg/kg**	**IV Over At Least 60 Minutes**	**Every 2 Weeks** *(at least 14 days apart)*	**12 Months**
DRUG	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**

Pre-Infusion:

☑ Confirm baseline MRI results prior to initiation of treatment.
☑ Confirm MRI completed and reviewed by prescriber prior to the 3rd, 5th, 7th, and 14th treatment.
☑ Measure and record weight prior to each treatment to determine dose.
☑ **Hold infusion and notify provider if patient reports:**

- Headache.
- Dizziness.
- Nausea.
- Vision changes.
- New or worsening confusion.

Post-Infusion:

☑ Educate patient/caregiver to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.