REVITALIZE
INFUSION CENTER

Leqembi®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Alzheimer's disease with early onset	ICD-10 Code: G30.0
☐ Alzheimer's disease with late onset	ICD-10 Code: G30.1
☐ Other Alzheimer's disease	ICD-10 Code: G30.8
☐ Alzheimer's disease, unspecified	ICD-10 Code: G30.9
☐ Mild Cognitive impairment, so stated	ICD-10 Code: G31.84
☐ Other_____	ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- CMS Registry Documentation/Confirmation
- Medication List
- Required Information:
  - Amyloid beta (+) PET scan or lumbar puncture
  - Recent MRI prior to initiating Leqembi to assess ARIA risk
  - ApoE 4 Results (if available)

Height: _____

Weight: _____

Leqembi (lecanemab-irmb) Orders:

☐ New Starts: Administer 10 mg/kg (_____ mg) every 2 weeks for 12 months

☐ After 18 months: Administer 10 mg/kg (_____ mg) every 4 weeks for 12 months

***** Note: ARIA monitoring MRI to be conducted before infusions 5, 7, and 14 and if symptoms of ARIA occur*****

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg PO ☐ Loratadine 10 mg PO

☐ Cetirizine 10 mg PO ☐ Other: _____

Lab Orders:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus