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 3, 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 #:**

Please fax the completed order form an all other requested information to: 601-714-1569

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

Revitalize Revitalize Locations Infusion Plus