Leqembi Order Form

Select patient referral location: ☐ Anchorage ☐ Palmer ☐ Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐ M ☐ F	Weight:
Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable):*	

2. PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION *(and year of diagnosis)*

All G30.X codes require secondary F02.8X Code

- ☐ G30.0 Alzheimer's Disease, Early Onset
- ☐ G30.1Alzheimer's Disease, Late Onset
- ☐ G30.8 Other Alzheimer's disease
- ☐ G30.9 Alzheimer's disease, unspecified
- ☐ G31.84 Mild Cognitive Impairment, So Stated
- ☐ F02.80 Dementia without behavioral disturbance
- ☐ F02.81 Dementia with behavioral disturbance

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: _____ Result: _____
- ☐ ApoE E4 Genetic Test. Date: _____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION *(requires new order every 12 months)*

PRE-INFUSION

- ☐ Confirm baseline MRI results prior to initiation of treatment
- ☐ Confirm MRI completed and reviewed by prescriber prior to 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 / Nausea / Dizziness / Vision changes / New or worsening confusion

ADMINISTER LEQEMBI

- ☐ 10mg/kg intravenously over at least 60 minutes.
- ☐ Dilute required volume of lecanemab-Irmb in 250 ml 0.9% Sodium chloride and infuse using a low-protein binding 0.2 micron in-line filter.
- ☐ If infusion reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

TREATMENT FREQUENCY

- ☐ Schedule treatment every two weeks (at least 14 days apart)

POST INFUSION

- ☐ Educate patient/care partner to report headache, dizziness, nausea, vision changes, or new/worsening confusion
- ☐ Fax treatment notes to provider after each infusion.

6. SIGNATURE *(required)*

PHYSICIAN'S SIGNATURE _____ DATE _____

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