LEQEMBI
(lecanemab-irmb)

FLOURISH™
HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Demographics • Medication List • Tried/Failed Therapies • Medicare Registry #_____

• MRI within 1 year • CSF or PET Scan Showing Amyloid Pathology • Cognitive Assessment & Score • Most Recent Labs

PRIMARY AND SECONDARY DIAGNOSIS

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
☐ G30.1 Alzheimer's disease with late onset
☐ G30.9 Alzheimer's disease, unspecified
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Leqembi

☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 5th, 7th, and 14th infusions

☐ Leqembi 10mg/kg IV (calculated dose_____mg) every 2 weeks
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI:	☐ Email:

_____ _____

Provider Signature Date