LEQEMBI® (lecanemab)

Provider Order Form *rev. 10/31/2025*

IVCARE INFUSION

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Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

CMS Registry Number (If already registered) _____

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Address: _____ **Patient Email:** _____

☐ NKDA Allergies: _____ **Weight (lbs/kg):** _____ **Height:** _____

ICD-10 Code (required): _____ **ICD-10 Description:** _____ **Last Treatment Date:** _____ **Last 4 SSN:** _____

Provider Information

Referral Coordinator Name: _____ **Referral Coordinator Email:** _____

Ordering Provider: _____ **Referring Practice Name:** _____

Practice Address: _____ **City:** _____ State: _____ Zip: _____

NURSING

☑ Provide nursing care per IVCare Infusion's Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ Every _____

☐ CMP ☐ At each dose ☐ Every _____

☐ CRP ☐ At each dose ☐ Every _____

☐ CSF or Plasma Biomarkers _____

PREMEDICATIONS

☐ Acetaminophen (Tylenol) ☐ 500 mg / ☐ 650 mg / ☐ 1000 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Loratadine (Claritin) 10 mg PO

☐ Diphenhydramine (Benadryl) ☐ 25 mg / ☐ 50 mg / ☐ PO / ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40 mg / ☐ 125 mg IV

Hydrocortisone (Solu-Cortef) ☐ 100 mg IV

☐ Other: _____ ☐ PO / ☐ IV

☐ Dose: _____ Frequency: _____

MEDICATION ORDER

☐ Standard Dosing

✓ Leqembi 10mg/kg IV every 2 weeks.

Each infusion to be given over approximately one hour.

Required Documentation to Initiate this Phase:

✓ MRI of brain within one year prior to first infusion.

✓ Date of MRI: _____

☐ By checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET.

☐ Optional Dosing after 18 months

✓ Leqembi 10mg/kg IV every 4 weeks

Each infusion to be given over approximately one hour.

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

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

SPECIAL INSTRUCTIONS

_____

Provider Name (Print) _____ **Provider Signature** _____ **Date** _____

Email: info@ivcareinfusion.com or fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to (615) 471-8674