LEQEMBI® (lecanemab)

ProviderOrderForm rev. 1/25/2026

IVCARE INFUSION

- ☐ Saint Cloud, FL
- ☐ Lake Mary-Sanford, FL
- ☐ Nashville, TN
- ☐ Gallatin, TN

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.

SPECIAL INSTRUCTIONS:

Referring provider is responsible for obtaining an MRI prior to the 3rd, 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.**

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

TN

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