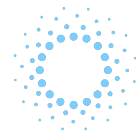
EFax: 561-516-6626 | Email: Info@infuseone.com | Phone 561-337-4055



INFUSE ONE

Leqembi Infusion Order

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please provide ICD10 code)

☐ Other:

☐ NKDA Allergies:

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

PRE-MEDICATION

- ☐ Acetaminophen1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Ceterizine 10mg PO
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP

REQUIRED DOCUMENTATION :

- ☑ Clinical notes with amyloid beta confirmation
- ☐ Recent baseline brain MRI prior to initiating treatment
- ☐ MRI prior to 5th infusion
- ☐ MRI prior to 7th infusion
- ☐ MRI prior to 14th infusion

LEQEMBI ORDERS

DOSING:

☐ 10mg/kg every 2 weeks

CMS Requirement:

☐ MoCA (or other cognitive test) score ________________

☐ FAQ (or other functional test) score ________________

REFILLS:

☐ ____________

(if not indicated prescription will expire one year from date signed)

☑ **Infuse One Standing Orders:**

Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

____

Provider Name

____

Provider Signature

____

Date