

LEQEMBI® (lecanemab-irmb)
Order/Referral Form



Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information		
Patient Name:	Patient DOB:	
Referral Status		
<input type="checkbox"/> New Referral <input type="checkbox"/> Restart/Continuation <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> D/C Infusions		
Diagnosis and ICD 10 Code		
<input type="checkbox"/> Diagnosis:	ICD 10 Code:	
<input type="checkbox"/> Diagnosis:	ICD 10 Code:	
<input type="checkbox"/> Diagnosis:	ICD 10 Code:	
Supporting Documentation		
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis	
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests including baseline MRI	
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Current Medication List	
<input type="checkbox"/> Cognitive Assessment Score _____	<input type="checkbox"/> Confirmed the presence of amyloid pathology (+CSF or amyloid PET scan)	
<input type="checkbox"/> CMS CED Registry Number _____	<input type="checkbox"/> APOE ε4 Carrier Status	
Medication Orders		
<input type="checkbox"/> Dose: LEQEMBI® 10mg/kg IV <input type="checkbox"/> Dose: LEQEMBI® _____ LEQEMBI® _____		
*Each drug is mixed in 250ml 0.9 NS and infused over one hour every two weeks. Each infusion flushed with 0.9% sodium chloride upon completion of infusion. *Note: Infusion center to obtain the MRI results and validate with the ordering provider to proceed with infusion before the 5 th , 7 th , and 14 th infusion.		
Premedication		
<input type="checkbox"/> Acetaminophen (PO): <input type="checkbox"/> 500mg, <input type="checkbox"/> 650mg, <input type="checkbox"/> 1,000mg OR Ibuprofen (PO): <input type="checkbox"/> 200mg, <input type="checkbox"/> 400mg, <input type="checkbox"/> 600mg <input type="checkbox"/> Loratadine 10mg (PO) OR <input type="checkbox"/> Diphenhydramine (PO): <input type="checkbox"/> 25mg, <input type="checkbox"/> 50mg <input type="checkbox"/> Famotidine 20mg (PO) prior to methylprednisolone <input type="checkbox"/> Methylprednisolone IV: <input type="checkbox"/> 125mg, <input type="checkbox"/> 250mg, <input type="checkbox"/> 500mg, <input type="checkbox"/> 1,000 mg, <input type="checkbox"/> Other: _____ mg <input type="checkbox"/> Hydrocortisone Sodium Succinate (Solu Cortef) 100 mg IVP <input type="checkbox"/> Other (medication, dose, route, and frequency): _____		
Labs		
<input type="checkbox"/> CMP – frequency: _____ <input type="checkbox"/> BMP – frequency: _____ <input type="checkbox"/> HBV – frequency: _____ <input type="checkbox"/> HIV – frequency: _____ <input type="checkbox"/> CBC w/o diff - frequency: _____ <input type="checkbox"/> CBC w/diff - frequency: _____ <input type="checkbox"/> CBC w/man diff - frequency: _____ <input type="checkbox"/> Urine pregnancy test prior to each infusion <input type="checkbox"/> Other labs (e.g. thyroid, Blood Glucose) and frequency: _____		
Notes (Additional Info)		
Adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.		
Prescriber Information		
Prescriber Name:	NPI #:	
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:	Date: <small>(Order valid for one year)</small>	
My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.		
We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.		

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