LEQEMBI® (lecanemab-irmb) 100 mg/mL

Horizon Infusions

Location

- ☐ Camillus
- ☐ Liverpool
- ☐ New Hartford
- ☐ Watertown

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4. PRIMARY AND SECONDARY DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

Primary Diagnosis

☐ Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis

- ☐ G30.0 Alzheimer's disease w/early onset
- ☐ G30.1 Alzheimer's disease w/late onset
- ☐ G30.8 Other Alzheimer's disease
- ☐ G30.9 Alzheimer's disease, unspecified
- ☐ G31.84 Mild cognitive impairment, unknown etiology

5. PRESCRIPTION INFORMATION (*requires a new order every 12 months*)

***Recent baseline brain MRI required prior to initiating treatment**

***Referring provider is responsible for obtaining an MRI within approximately one week prior to the 3rd, 5th, 7th, and 14th infusions**

- ☐ Administer 10 mg/kg IV over 1 hour Q2 weeks for 18 months
- ☐ After 18 months, 10mg/kg at frequency of:
  - ☐ Q2 weeks ☐ Q4 weeks

-CMS Registry Letter Received and Attached

☐ Yes ☐ No Registry Trial #: NCT06058234

☐ Other _____

- ☐ Vital signs per HI Protocol
- ☐ Anaphylaxis & Hydration Mgmt per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

6. LABS

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

- ☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
- ☐ Other (*specify*): _____

7. SIGNATURE (required)

_____ _____

PHYSICIAN'S SIGNATURE **DATE**