LEQEMBI® (lecanemab-irmb) 100 mg/mL

Horizon Infusions

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**

☐ **Q2 weeks** ☐ **Q4 weeks**

-CMS Registry Letter Received and Attached

☐ **Yes** ☐ **No** **Registry Trial #:** _____

☐ **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**