



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
<b>INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front &amp; back)</b>			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
<b>CLINICAL INFORMATION</b>			
<input type="checkbox"/> G30.0 Alzheimer's Disease With Early Onset <input type="checkbox"/> G30.1 Alzheimer's Disease With Late Onset <input type="checkbox"/> G30.9 Alzheimer's Disease, Unspecified <input type="checkbox"/> Other (Please Specify Diagnosis): _____ Patient has confirmed presence of amyloid beta pathology: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Please Check to Confirm Understanding:</b> Obtain a recent baseline brain magnetic resonance imaging (MRI) prior to initiating treatment with LEQEMBI. Obtain an MRI prior to the 5th, 7th, and 14th infusions. If a patient experiences symptoms suggestive of ARIA, clinical evaluation should be performed, including an MRI if indicated. **Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
<b>LEQEMBI® ORDERS</b>			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
<b>Medication</b>		<b>Dose/Frequency</b>	<b>Refills</b>
<input type="checkbox"/> Leqembi® (lecanemab-irmb) 500 mg/5 mL (100 mg/mL) <input type="checkbox"/> Leqembi® (lecanemab-irmb) 200 mg/2 mL (100 mg/mL)		<input type="checkbox"/> 10 mg/kg intravenous infusion over approximately one hour, once every two weeks. <input type="checkbox"/> Other: _____	
<b>Pre-Medication</b>	<b>Dose/Strength</b>	<b>Directions</b>	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg <input type="checkbox"/> _____mg	<input type="checkbox"/> Take by mouth prior to each infusion	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> Take by mouth prior to each infusion <input type="checkbox"/> Administer via IV prior to each infusion	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Administer via IV prior to each infusion <input type="checkbox"/> Other: _____	
<input type="checkbox"/> _____	_____	_____	
<b>ANAPHYLACTIC REACTION (AR):</b>			
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr <input type="checkbox"/> Other: _____			



**LEQEMBI®**

**Please Fax Completed Form To: 888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

**SIGNATURE**

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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