PURE INFUSION SUITES

Fax form to:
1-801-931-2631
you must enter a 1 before the fax number

LEQEMBI (LECANEMAB) ORDER FORM

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis:

Allergies

***Please fax a copy of the following patient information: Demographics, Insurance, Current Medications, H&P with Alzheimers Diagnosis, MMSE/MoCA (or other screening test),** Lumbar Puncture, **Current Lab Results, MRI Within one Year**

*ICD 10 CODE

***Please include supporting clinical documentation for specified ICD 10 Code as well as demographic and insurance information. This must be provided to ensure payment by insurance carrier. Please fax with this order form.**

Leqembi (Lecanemab) IV Dosage & Schedule:

- ☐ Doses 1-4 at 10mg/kg q2 weeks - **MRI Needed**
- ☐ Doses 5-6 at 10mg/kg q2 weeks - **MRI Needed**
- ☐ Doses 7-13 at 10mg/kg q2 weeks - **MRI Needed**
- ☐ Doses 14+ at 10mg/kg q2 weeks - **MRI per Provider Preference**

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date/Time

Provider Phone | Provider Fax

Special needs/notes: