

Lecanemab (Leqembi)



Provider Order Form Revised 10/30/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code: G30.0 G30.1 G30.8 G31.84 Other: _____
ICD 10 Description: _____
 NKDA Allergies: _____ Weight (lb/kg) _____ Height: _____
Patient Status: New to Therapy New to Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip: _____

REFERRING PROVIDER

By checking this box, I acknowledge I am responsible for ordering and reviewing all MRIs required for this therapy. I am responsible for communicating results to the patient/guardian.
Patients will not be scheduled for their appointment prior to receiving clearance confirmation from prescribing physician.
 Referring provider has registered patients with Medicare and Medicare Advantage in the CMS registry and provide proof of registration. **Patients will not be scheduled without enrollment confirmation.**
(<https://qualitynet.cms.gov/alzheimers-ccd-registry/submission>)
MBI: NCT _____ Issue #: ALZH- _____
Submission Date: _____

NURSING

Results of follow-MRIs will be required PRIOR to administering the 3rd, 5th, 7th, and 14th infusions
 Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI
 Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other: _____
 Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

SPECIAL INSTRUCTIONS

PRE-MEDICATION ORDERS

Not typically indicated for this medication.
 acetaminophen (Tylenol) 500 mg/ 650 mg/ 1000 mg PO
 cetirizine (Zyrtec) 10 mg PO
 loratadine (Claritin) 10 mg PO
 diphenhydramine (Benadryl) 25 mg/ 50 mg PO/ IV
 methylprednisolone (Solu-Medrol) 40 mg/ 125 mg IV
 hydrocortisone (Solu-Cortef) 100 mg IV
 Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

Lecanemab (Leqembi) Intravenous Infusion.
 Dose: 10mg/kg
 Route: Intravenous
 Rate: Infuse over one hour
 Frequency: Every 2 weeks / Every 4 weeks
After 18 months of therapy, re-evaluate frequency and continue treatment once every 2 weeks or once every 4 weeks.
 Flush with 0.9% sodium chloride after infusion completion
 Refills: Zero/ for 12 months/ Other: _____
(If not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must *handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.*

Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

Provider Name (Print)

Provider Signature

Date