INTRAMED Plus
infusion services

LEQEMBI®

INFUSION & MEDICAL CENTER

1. **Patient Name** _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. **Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: _____ Alzheimer's disease with early onset — ICD-10 Code: G30.0
_____ Alzheimer's disease with late onset — ICD-10 Code: G30.1
_____ Alzheimer's disease, unspecified — ICD-10 Code: G30.9
_____ Other:_____ — ICD-10 Code: _____

3. Allergies:_____(or attach list)

Clinical Information – Please fax with Infusion Order Form:

- Clinical notes and test supporting primary diagnosis
- Recent Lab Results including
  - Including recent MRI results (within one year)
  - Confirmed presence of amyloid pathology
- Medication List

Patient
Weight: _____ lbs.
Height: _____ in.

LEQEMBI ™ (lecanemab-irmb)

Code: J0174

4. **Drug Order:**

Administer 10 mg/kg (_____mg) IV over one hour every 2 weeks _____# Refills (Recommend 25 Refills)

MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusion

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** _____ / _____ Date: _____
Dispense as written — Substitution permitted

Printed Physician's Name with Credentials:_____ NPI: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760