Jean Walter Leqembi Order Form

P: 443-354-3772 F: 443-354-3767

Patient Name

DOB: Phone number:

Full Address:

Allergies: Referring Provider:

NPI/DEA: Office contact and phone number:

PATIENT HEIGHT AND WEIGHT: _____

DOCUMENTATION PROVIDED:	**Yes**	**No**
1. Baseline MRI done within 12 months? *Please attach report.	◯	◯
2. Completed Leqembi Diagnostic Checklist. *Located on Leqembi website.	◯	◯
3. If APoE is **POSITIVE AND HOMOGENOUS**-Send documentation indicating result has been reviewed and Leqembi is still indicated.	◯	◯
4. If patient has **MEDICARE**-Have they been registered through the CMS Registry? *Please attach submission with patient ID number.	◯	◯
5. Has the patient had a PET scan done? *Please attach report.	◯	◯

Order details:

Please select all that apply (This order is valid for 6 months):

◯ Leqembi 10mg/kg IV every 2 weeks (or fourteen days).

◯ Other: Leqembi 10mg/kg IV :

Refills:

Diagnosis code:

Premedications: ****If nothing is indicated below, we will use FDA recommendations****

◯ PLEASE CHECK HERE IF NO PREMEDICATION(S) REQUIRED

◯ Acetaminophen: _____mg ◯ Diphenhydramine: _____mg ◯ Other: _____

PRESCRIBER CERTIFICATION: By signing, I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed Leqembi to the previously identified patient or a physician's designee, and that I provided the patient with a description of Leqembi.

Provider Signature: _____ Date: _____