Leqembi (lecanemab)

Provider Order Form *rev. 1/2/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code & description)

Primary Diagnosis must be checked:

☐ Z00.6 Encounter for examination for normal comparison and control in clinical research program

Secondary Diagnosis:

☐ G31.84 Mild Cognitive Impairment Due to Alzheimer's Disease

☐ G30.0 Early Onset Alzheimer's Disease
☐ G30.1 Late Onset Alzheimer's Disease
☐ G30.8 Other Alzheimer's Disease
☐ G30.9 Alzheimer's Disease unspecified
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
- Cetirizine (Zyrtec) 10mgPO
- Loratadine (Claritin) 10mgPO
- Diphenhydramine (Benadryl)☐25mg ☐50mg ☐PO ☐IV
- Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
- Other: _____ Dose: _____ Route: _____

***Referring provider is responsible for obtaining an MRI prior to the 5th, 7th, and 14th infusions

Lab Orders

Required: ApoE ε4 Testing (if available)
Cognitive Assessment Score _____ (MMSE 20-28, CDR-GS 0.5 or 1)
MRI Within 1 Year Confirmed presence of amyloid pathology
CMS Registry Confirmation ALZH-_____ (Medicare and Medicare Advantage only)
Patient has been provided ARIA Risk counseling
☐ Other: _____

Leqembi (lecanemab-irmb) (Select one):

☐ 10 mg/kg (_____ mg) IV every 2 weeks
☐ 10 mg/kg (_____ mg) IV every 4 weeks (after 18 months of treatment only)
☐ Other: _____

Maintenance Dose: (can only be selected once patient has completed 18 months of standard dosing at the 2 week interval per the PI)

☐ 10mg/kg (_____mg) IV every 4 weeks
☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Refills: ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____
_____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454