Leqembi® (lecanemab) Referral Form

BIOHEALTH INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

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

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ Every _____
☐ CMP ☐ At each dose ☐ Every _____
☐ CRP ☐ At each dose ☐ Every _____
☐ Other _____

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

****MRIs should be performed at baseline & Prior to the 3rd, 5th, 7th, and 14th infusion****

LEQEMBI INITIATION PERIOD

☐ 10mg/kg IV every 2 weeks for 1 year (Dose 1-26)
☐ 10mg/kg IV every 2 weeks for 6 months (Dose 27-39)

LEQEMBI MAINTENANCE PERIOD

☐ 10mg/kg IV every 2 weeks
☐ 10mg/kg IV every 4 weeks
☐ 360mg/1.8ml Subcutaneous injection once weekly

If transitioning from starting dosage to a maintenance dosage regimen, administer the first maintenance dose 2 weeks after the last starting dose

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **MRI Within 1 Year**
☐ **Confirmed presence of amyloid pathology (*+CSF or amyloid PET scan*)**
☐ **Attach one (1) from each category:**
Functional: FAQ / Katz Index
Cognitive: MMSE / MoCA

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

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

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
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