PRESCRIPTION ORDER FORM

# LEQEMBI
## (lecanemab-irmb)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

### PATIENT DEMOGRAPHICS

| | |
|---|---|
| Patient Name: | Patient's Phone Number: |
| Date of Birth: | Address: |
| Allergies: See List ☐ NKDA ☐ | City, State, Zip: |
| Weight:_____lbs or _____kg | Patient's Email: |

### REQUIRED DOCUMENTATION

• Insurance Card • H&P • Demographics • Medication List • Tried/Failed Therapies • Medicare Registry #_____
• MRI within 1 year • CSF or PET Scan Showing Amyloid Pathology • Cognitive Assessment & Score • Most Recent Labs

### PRIMARY AND SECONDARY DIAGNOSIS

**Primary Diagnosis**
☑ Z00.6 Encounter for examination for normal comparison and control in clinical research program

**Secondary Diagnosis**
☐ G30.0 Alzheimer's disease with early onset
☐ G30.1 Alzheimer's disease with late onset
☐ G30.9 Alzheimer's disease, unspecified
☐ Other:_____

### LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

### PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐Solu-Medrol 40mg IVP ☐ Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO ☐ Other: _____

### PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 5th, 7th, and 14th infusions infuse over 1 hour
☐ Leqembi 10mg/kg IV (calculated dose_____mg) every 2 weeks
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

### LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

### PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

| | |
|---|---|
| Provider Name: | Office Contact: |
| Address: | Phone: |
| City, State, Zip: | ☐ Fax: |
| NPI **AND** License: | ☐ Email: |

Provider Signature _____ Date _____