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 ICD-10 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
- _____ Other Alzheimer's disease — ICD-10 Code: G30.8
- _____ Alzheimer's disease unspecified — ICD-10 Code: G30.9
- _____ Mild cognitive impairment, so stated — ICD-10 Code: G31.84

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

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

Patient
Weight: _____ lbs.
Height: _____ in.

LEQEMBI ™ (lecanemab-irmb)

J Code: J0174

4. Drug Order:

❑ Administer 10 mg/kg (or: _____mg) IV over one hour every 2 weeks — Refills x 1 year (26 doses)

❑ Administer 10 mg/kg (or: _____ mg) IV over one hour every 4 weeks (after 18 months of therapy) — Refills x 1 year (13 doses)

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

Pre-Medication Orders: _____

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

By signing this form and utilizing our 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: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**