

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- | | | | | |
|---------------------------------|-----------------------|-------------------------|--|---------------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics | 4. Medication List | 5. Tried/Failed Therapies |
| 6. Medicare Registry # _____ | | 7. MRI within 1 year | 8. CSF or PET Scan Showing Amyloid Pathology | |
| 9. Cognitive Assessment & Score | | 10. Most Recent Labs | | |

PRIMARY DIAGNOSIS

Primary Diagnosis

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

Secondary Diagnosis

- | | |
|---|--|
| <input type="checkbox"/> G30.0 Alzheimer's disease with early onset | <input type="checkbox"/> G30.1 Alzheimer's disease with late onset |
| <input type="checkbox"/> G30.9 Alzheimer's disease, unspecified | <input type="checkbox"/> Other _____ |

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: Acetaminophen PO 1000mg, cetirizine or loratadine 10mg PO or IV before each treatment
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Referring provider is responsible for obtaining an MRI prior to the 5th, 3rd, 7th, and 14th infusions

Leqembi 10mg/kg (_____mg) IV every 2 weeks Other _____
 FIRST DOSE?: Yes No Refill x12 months unless otherwise noted _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____