RESTORE HEALTH
INFUSION AND WELLNESS

LEQEMBI

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs, Diagnostic Testing and Imaging, CMS Registry Number, Clinical Trial Number

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB**: _____ **Gender**: ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

For Medicare Recipients: CMS Registry Number: _____ Clinical trial Number: NCT _____

If the patient is enrolled in the CMS National Patient Registry, please use NCT 06058234. If the patient is enrolled in a different CMS-approved CED registry, please use the assigned Clinicaltrials.gov number as appropriate. All Medicare patients must be enrolled in a qualifying study and will not be scheduled if information is not provided

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ G30.0 (Alzheimer's disease with early onset) ☐ G30.1 (Alzhemier's disease with late onset)
☐ G30.8 (Other AD) ☐ G30.9 (AD, unspecified) ☐ Z00.6 (+ AD Code for CMS Billing) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

Amyloid Confirmation: ☐ PET ☐ CSF **ARIA History:** ☐ Yes ☐ No

MRI Completed (Baseline + Prior to 3rd, 5th, 7th , 14th Infusion Required): ☐ Yes ☐ No

Please attach results to referral

TREATMENT

LEQEMBI (lecanemab)

Route: Intravenous infusion

Dose: ☐ 10mg/kg

Frequency:

☐ Every 2 weeks

☐ Every 4 weeks

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Quantity: _____ **Refills:** _____

Provider Signature: _____ Date: _____