BAMF Health Theranostics Center • Molecular Therapy Clinic
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LEQEMBI Order

Revision 09-8-2025

Please Fax completed order to BAMF Health at Fax # 616-253-8365

PATIENT INFORMATION

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

Patient Name: _____ DOB: _____

Allergies: _____ Weight (kg): _____ Height (cm): _____

ICD-10 Code(s) & Description:

NOTE: Please send all relevant demographic and insurance information

The patient has an existing prior authorization: ☐ Yes (please fax copy to BAMF Health) ☐ NO

REFERRING OFFICE

Contact Name: _____ Contact Phone #: _____

Ordering Provider: _____ Provider NPI: _____

Practice Name: _____ Phone #: _____ Fax #: _____

DIAGNOSIS

☐ Mild cognitive impairment, so stated (ICD-10 code: G31.84)
☐ Alzheimer's Disease with Early Onset (ICD-10 code: G30.0)
☐ Other: _____
(ICD-10 Code: _____)

☐ Alzheimer's Disease with Late Onset (ICD-10 code: G30.1)
☐ Mild dementia due to Alzheimer's Disease (ICD-10 code: G30.9)

CLINICAL HISTORY – REQUIRED INFORMATION

☐ Current Medication list
☐ Recent provider note(s)
☐ PET scan or CSF results with amyloid beta confirmation
☐ Recent MRI of brain (within past year)
☐ Results of cognitive assessment with score: _____ (MMSE 22-30,CDR-GS 0.5 or 1)

☐ Confirmation of functional impairment w/ validated tool:
☐ FAQ Score ☐ FAST ☐ CDR-SB
☐ For Medicare / Medicare Advantage, please include a copy of the CMS Registry enrollment that includes submission number
☐ APoE ε4 test results (if applicable)

PRE-MEDS FOR 1ST and 2nd DOSE ONLY

☐ Acetaminophen (Tylenol®) 650 mg PO prior to infusion
☐ Decadron 10 mg IVP over 10 minutes prior to infusion
Please instruct patient to take acetaminophen 650 mg every 6 hours routinely for the next 24 hours while at home.

PRE MEDS FOR SUBSEQUENT DOSES

☐ Acetaminophen (Tylenol®) 650 mg PO prior to infusion

NURSING ORDERS

☐ Vitals prior to infusion If SBP ≥ 150 mmHg, hold treatment and call provider.
☐ Vitals q15 min x1, end of infusion and prior to discharge
Patients to be monitored for 1 hr following their first and second infusion
Call prescriber and/or 911 for any hypersensitivity reactions including but not limited to fever, flu-like symptoms, nausea, vomiting, hypertension, and oxygen desaturation

THERAPY ADMINISTRATION

Drug: LEQEMBI (lecanemab-irmb) Dose: 10mg/kg Route: IV over 60 minutes

Frequency: Every 2 Weeks Refill: ☐ 6 months ☐ 1 year ☐ Other: _____

Date of last infusion if not at BAMF Health: _____ RX Expiration Date: _____

FOLLOW UP MR BRAIN w/o contrast (Please use checkboxes below for allowing BAMF Health Nurse navigators to coordinate follow up MRIs at BAMF Health)

Rule Out:	☐ Amyloid related imaging abnormalities (Brain Edema or Hemorrhage) ☐ Other:
Order:	☐ MR Brain w/o contrast (prior to 3rd Lecanemab infusion)
	☐ MR Brain w/o contrast (prior to 5th Lecanemab infusion)
	☐ MR Brain w/o contrast (prior to 7th Lecanemab infusion)
	☐ MR Brain w/o contrast (prior to 14th Lecanemab infusion)

Additional Orders: By signing this order you agree to the following orders, unless otherwise noted.

- Hold infusion and notify provider if patient reports: Headache, Dizziness, Nausea, Vision Changes, New or Worsening Confusion.
- May initiate IV catheter patency protocol
- Infusion/allergic reactions may be managed per facility protocol.

Provider Signature: _____ Date: _____