Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Lecanemab-irmb)

Leqembi infusion orders

INFUSE ONE

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Alzheimer's Disease ☐ _____ Other

PRE-MEDICATIONS

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ (other)
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ (other)

Leqembi (Lecanemab-irmb) ORDERS

DOSAGE & FREQUENCY

☐ 10mg/kg IV once every 2 weeks

Obtain an MRI prior to the 5th, 7th, and 14th infusions.

Patient Weight

_____ lbs

_____ kg

NOTES:

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____