



JUPITER
INFUSION

Jupiter Infusion
140 Jupiter Lakes Blvd, Suite A
Jupiter, FL 33458
Office: 561-277-9211

LEQEMBI (lecanemab) ORDER FORM
P: 561 277 9211 Fax: 561 277 9226

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561 277 9226

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy Next Treatment Date: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Diagnosis:

- Alzheimer’s Disease w Early Onset (ICD-10:G30.0)
- Alzheimer’s Disease w Late Onset (ICD-10: G30.1)
- Other Alzheimer’s Disease (ICD-10: G30.8)
- Alzheimer’s Disease, unspecified (ICD-10: G30.9)
- Mild Cognitive Impairment (ICD-10: G31.84)

THERAPY ORDER

Leqembi: 10 mg/kg IV every 2 weeks for: (please select one)

- First 5 doses
- 6 months
- 1 year
- Other: _____

- MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusions
- HOLD INFUSION IF MRI IS NOT PERFORMED AT INDICATED INTERVAL

ADDITIONAL REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Patient enrolled in the CMS National Patient Registry (Medicare and Medicare Advantage required)
Issue number: _____ Date of registry enrollment: _____
- Confirmed presence of amyloid pathology. Attach results: Amyloid PET scan OR +CSF (cerebrospinal fluid)
- MRI of the brain (within 1 year) – attach results
- Cognitive assessment scores (list all available, attach results):
 MMSE: Score _____ Date of assessment _____
- Functional assessment score: _____ (attach results)
- Does the patient have objective impairment in episodic memory as evidenced by a memory test (i.s., Fred and Cued, Wechsler, etc.)? ****BCBS required**** Yes No
- Is the patient on therapeutic anticoagulant therapy? Yes No

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

