Leqembi

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

Please include the following to expedite the order:
Medication list, Insurance Info, most recent office visit note(s)/H&P substantiating diagnosis including assessments of cognitive function, brain imaging/testing confirming presence of amyloid beta pathology (i.e., PET, LP), **recent** brain MRI establishing presence/lack of pre-existing ARIA, and results of ApoE e4 genetic testing if done.
****Results of follow-up MRIs will be required PRIOR to administering the 5th, 7th, and 14th infusions.**

☐ Follow-up brain MRIs have been ordered and will be completed at (note facility) _____

Leqembi CMS Registration #: ALZH _____
Providers, please note patients will NOT be scheduled without this number.

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ G30 ☐ G30.0 ☐ G30.1 ☐ G30.9

Other Dx/ICD10: _____

PROVIDER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Leqembi Dosage:

Date of Last Treatment, If Continuation:

Dose: ☐ **10 mg/kg** ☐ _____ **Total Dose:** _____ **Route:** IV

Frequency: ☐ **once every 2 weeks** ☐ _____

Start Date of infusion: _____