CURBSIDE
INFUSION SERVICES

Patient Name: ______________________________________

Date of Birth: ________________ Wt: ________Ht:________

Allergies: ____

Alzheimer Treatment Order Form

- **Orders are initiated unless crossed out by provider.**
- ❑ **Check box to initiate order**

Please complete this order form and include demographics, insurance information, supporting clinical notes,suporting MRI most recent, Amyloid PET scan or CSF, labs, and medication list fax to (888)-360-2466

Diagnoses:

Diagnosis	Code
❑ Alzheimer's Disease with Early Onset	ICD-10: G30.0
❑ Alzheimber's Disease with Late Onset	ICD-10: G30.1
❑ Other Alzheimer's Disease	ICD-10: G30.8
❑ Alzheimer's Disease, unspecified	ICD-10: G30.9
❑ Mild Cognative Impairment	ICD-10: G31.84
❑ Encounter for clinical registry program	ICD-10: Z00.6 MCR required

Medication Orders:

- Leqembi (lecanemab) ❑ 10mg/kg IV every 2 weeks
- *MRIs should be done and on-file at baseline and prior to infusion 5, 7 and 14*
- *Hold infusion if MRI is not performed at required intervals*

Refill for: ❑ 6 months ❑ 1 year
❑ Other: ___________________

- Kisunla (donanemab) ❑ Start: 700mg IV every 4 weeks for 3 doses, then 1400mg IV every 4 weeks thereafter
  ❑ Maintenance:1400mg IV every 4 weeks

Refill for: ❑ 6 months ❑ 1 year
❑ Other: ___________________

- *MRIs should be performed at baseline and prior to infusion, 2, 3, 4 and 7*
- *Hold infusion if MRI is not performed at required inverals*

Pre-Medications:

❑ Acetaminophen:_____325mg_____500mg_____650mg PO
❑ Loratadine:_____10mg PO
❑ Cetirizine:_____10mg PO
❑ Diphenhydramine:_____25mg_____50mg PO
❑ Famotidine:_____ 20mg_____40mg PO
❑ Ibuprofen:_____200mg_____400mg_____600mg PO
❑ Ondansetron:_____4mg_____8mg PO

❑Dexamethasone:_____4mg_____8mg IV
❑Diphenhydramine:_____25mg_____50mg IV
❑Famotidine:_____20mg_____40mg IV
❑Methylprednisolone:_____125mg IV
❑Hydrocortisone:_____100mg IV
❑Ondansetron:_____4mg_____8mg IV

CMS National Patient Registry : ❑ Issue #:___________________Date of Registry Enrollment:______________

Nursing Orders:

❑
- Infusion Nurse to insert peripheral IV prn for infusion therapy
- Monitor for infusion reactions during infusion
- Implement standing anaphylaxis protocol as needed

_______________________________________ ____________________
Prescriber Signature *Date*

_______________________________________ ____________________
Please Print Name NPI Phone / Fax/ Contact Person