

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 713-489-9955

Diagnoses:	<ul><li>□ Alzheimber¹</li><li>□ Other Alzhe</li><li>□ Alzheimer¹s</li><li>□ Mild Cognat</li></ul>	Disease with Early Onset s Disease with Late Onset imer's Disease Disease, unspecified ive Impairment or clinical registry program	ICD-10: G30 ICD-10: G30 ICD-10: G30 ICD-10: G30 ICD-10: G31 ICD-10: Z00	.1 .8 .9
Medication C	)rders:			
<ul> <li>Leqem</li> <li>MRIs sho</li> <li>Hold infus</li> </ul>	bi (lecanemab) uld be done and on- sion if MRI is not per	□ 10mg/kg IV every 2 weeks file at baseline and prior to infusion 5, formed at required intervals	7 and 14	Refill for:  6 months 1 year Other:
	a (donanemab)	☐ Start: 700mg IV every 4 we 1400mg IV every 4 weeks ☐ Maintenance:1400mg IV expanding IV expansion and prior to infusion, 2, 3, 4 a	thereafter very 4 weeks	Refill for: 6 months 1 year Other:
		rformed at required inverals		
☐ Loratadine ☐ Cetirizine: ☐ Diphenhyo ☐ Famotidine ☐ Ibuprofen:	phen:325m :10mg PO 10mg PO ramine:25n e:20mg_	g500mg650mg PO  ng50mg PO40mg PO40mg PO8mg PO	□ Dexamethasone: □ Diphenhydramine:_ □ Famotidine:20 □ Methylprednisolone □ Hydrocortisone: □ Ondansetron:	25mg50mg IV 0mg40mg IV :125mg IV 100mg IV
		try : □ Issue #:		
◆ Monitor	n Nurse to insert for infusion rea	peripheral IV prn for infusion the ctions during infusion aphylaxis protocol as needed	nerapy	
Prescriber S	Signature		Date	
<u></u>				
Please Prin	Name	NPI	Phone / I	Eay/ Contact Porcon