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 713-489-9955

Diagnoses:

❑ 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

  Refill for: ❑ 6 months ❑ 1 year ❑ Other: _____
- *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*
- Kisunla (donanemab) ❑ Start: Infuse every four weeks as follows: Infusion 1: 350 mg, Infusion 2: 700 mg, Infusion 3: 1,050 mg 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