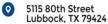


Houssam Al Kharrat Gastroenterology





Phone: (806) 788-4368 Fax: (806) 513-2863



LEQEMBI (lecanemab-irmb) Name:_____ DOB:__ M O F O Patient Weight lbs Phone #1 :_____(H/W/C) Phone #2:_____(H/W/C) kg Allergies: **PRE-MEDICATION ORDERS** OTylenol 500-1000mg PO PRN OBenadryl 25mg PO PRN OSolu-Cortef _____ mg SIVP Diagnosis (ICD-10): OG30.0 Alzheimer's Disease with Early Onset OR OG30.1 Alzheimer's Disease with Late Onset OR OG30.8 Other Alzheimer's Disease + Fither OF02.80 Dementia without Behavioral Disturbance OR OF02.81 Dementia with Behavioral Disturbance OG31.84 Mild Cognitive Impairment, so Stated Oother: Code: ______ Description: ______ **LEQEMBI ORDER:** O10mg/kg every 2 weeks O mg/kg every weeks REQUIRED: PET scan or CSF results with amyloid beta confirmation, recent MRI of brain (within past year), results of cognitive assessment, and a letter of medical necessity. REQUIRED: Repeat Brain MRI must be obtained prior to infusion 5, 7, and 14. NOTES: ORDERING PROVIDER Signature X_____ Date_____ Provider Phone Fax