

## LEQEMBI ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height (in): \_\_\_\_\_ Weight (lb): \_\_\_\_\_ Referral Status:  New  Updated  Renewal

### Infusion/ Injection Information

Primary ICD-10 Code: \_\_\_\_\_ Primary ICD-10 Description: \_\_\_\_\_

Other ICD-10 Codes: \_\_\_\_\_ Other ICD-10 Descriptions: \_\_\_\_\_

#### Ocrevus (Ocrelizumab) Dosing Info:

- 10mg/kg IV every 2 weeks  
 Other: \_\_\_\_\_

#### Required Documentation:

- Full Patient Chart  
 Insurance Cards (Front and Back)  
 Clinical Notes Supporting Diagnosis  
 List of Current Medications, Conditions, and Allergies  
 CMS Registry Confirmation Email (Medicare Patients)  
 MRI (Within 1 Year)  
 Positive CSF or Amyloid PET Scan  
 Cognitive Assesment Score \_\_\_\_\_

#### Premedications:

- Acetaminophen \_\_\_\_\_ mg  
 PO  IV  
 Cetirizine \_\_\_\_\_ mg  PO  
 Diphenhydramine \_\_\_\_\_ mg  
 PO  IV  
 Hydrocortisone \_\_\_\_\_ mg  IV  
 Loratadine \_\_\_\_\_ mg  PO  
 Methylprednisolone \_\_\_\_\_ mg  IV  
 Other: \_\_\_\_\_ mg  
 PO  IV

### Ordering Provider Information

Practice Name: \_\_\_\_\_ Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ Referral Coordinator Name: \_\_\_\_\_

Referral Coordinator Email: \_\_\_\_\_ Referral Coordinator Phone: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date