Leqembi®

Provider Order Form Rev. 07/2024

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: ____________________ DOB: ____________ Phone: ____________

Address: ____________________ City/ST/Zip: ____________________

Allergies: ____________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: _______ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

**ICD 10 Code Required*

Mild Alzheimer's Disease Dementia

- ☐ Alzheimer's disease with early onset, G30.0
- ☐ Alzheimer's disease with late onset, G30.1
- ☐ Other Alzheimer's disease, G30.8
- ☐ Alzheimer's disease, unspecified, G30.9

Mild Cognitive Impairment due to Alzheimer's Disease

- ☐ Mild cognitive impairment, G31.84

Secondary diagnosis ☐ For Medicare: must include ICD10 Z00.6

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Leqembi® (lecanemab-irmb)	________ mg (10 mg/kg)	Infuse IV over 1 hour once every 2 weeks x 1 year ☐ Observe patient for 4 hours after infusion 1, for 2 hours after infusions 2-6, and if no reactions for 30 minutes for all subsequent infusions.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: ____________________

Date of last treatment: ____________ Date of next treatment: ____________

PRE-MEDICATION ORDERS

- ☐ No premeds ordered at this time
- ☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
- ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
- ☐ Other: ____________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

- ☐ No labs ordered at this time
- ☐ CBC w/diff and Platelets q ________ ☐ CMP q ________
- ☐ Other: ____________________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ____________________ Date: ____________

Physician Name: ____________ NPI: ________ TIN: ________ Specialty: ________

Address: ____________________ City/ST/Zip: ____________

Contact Person: ____________ Phone #: ____________ Fax #: ____________

Email Where Follow Up Documentation Should Be Sent: ____________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has been diagnosed with Alzheimer's disease. Date of clinical diagnosis (required): ____________

☐ The patient has documented mild cognitive impairment or mild dementia stage of Alzheimer's disease.

Please indicate method(s) for assessment and attach copy:

- ☐ Montreal Cognitive Assessment (MoCA)
- ☐ Mini-Mental State Exam (MMSE)
- ☐ Other: ____________________
- ☐ Alzheimer's Disease Assessment Scale (ADAS-Cog14)
- ☐ St. Louis University Mental Status Exam (SLUMS)

☐ The patient's functional abilities have been assessed.

Please indicate method(s) for assessment and attach copy:

- ☐ Functional Activities Questionnaire (FAQ)
- ☐ Functional Assessment Staging Tool (FAST)
- ☐ Other: ____________________
- ☐ Alzheimer's Disease Cooperative Study – Activities of Daily Living Inventory Scale (ADCS-ADL-MCI)

☐ A Clinical Dementia Rating-Global Score (CDR-GS) was completed. ***Please attach copy of assessment form.***

☐ The patient has a positive biomarker for beta amyloid plaques.

- ☐ Amyloid positron emission tomography (PET) scan
- ☐ Cerebrospinal fluid (CSF) testing
- ☐ Other: ____________________

☐ The patient has a recent (within one year) brain MRI scan. Date of MRI: ____________

****Referring provider is responsible for scheduling and obtaining an MRI prior to the 5th, 7th, and 14th infusions.***

☐ A genotype testing for ApoE ε4 status was completed. ***Please attach copy of test result.***

☐ The patient will not be receiving anticoagulation therapy or antiplatelets while on Leqembi®.
If currently on anticoagulants or antiplatelets, please specify drug and dose: ____________________

LAB AND TEST RESULTS (required)

☐ Amyloid PET scan ☐ CSF biomarker results ☐ MRI brain scan ☐ ApoE ε4 status results ☐ Other: ____________

For Medicare patients: ☐ Referring practice to complete CED Study Registry submission; Initial Registry #: ALZH-__________
☐ Healix Infusion Care to submit and manage CED Study Registry submission on behalf of referring provider/practice