Leqembi Referral Form

Fax completed form to: 833-908-1122

amerita specialty infusion services | Ivy Specialty Infusion an amerita company | mosaic infusion solutions an amerita company

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:		
Allergies:		

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Line access documentation/verification if applicable
- ☐ Baseline and most recent MRI results (within the past year)
- ☐ Imaging to confirm presence of amyloid beta pathology via MRI or PET scan
- ☐ APOE ε4 Carrier Status
- ☐ Documentation of mild cognitive impairment
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

Flush Orders: *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed ☐ Other

Lab Orders:

Lab Date & Frequency:

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)
- ☐ Epinephrine 0.3mg IM as needed
- ☐ Solu-cortef 250mg-500mg IV infusion as needed
- ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
- ☐ Diphenhydramine ________ mg IV infusion as needed
- ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed
- ☐ Other

Pre-Medications: Per prescribing information: Pre-medications of antihistamine, corticosteroid and analgesic is recommended
(Check all that apply)
- ☐ Acetaminophen ________mg PO ________ minutes prior to infusion
- ☐ Solu-Medrol ______mg IV infusion ______minutes prior to infusion
- ☐ Diphenhydramine ________ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion
- ☐ Other

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_________________ When is patient due for next dose?_________________		
☐ Leqembi	☐ 10mg/kg IV in 250mL 0.9% Normal Saline ☐ gravity or ○ pump through a low-protein binding 0.2 micron in-line filter over 1 hour once every 2 weeks **Note:** Obtain MRI prior to 5th, 7th and 14th infusion. MRI results must be cleared by MD in order to proceed to next infusion.	________
☐ OTHER		________

By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature **<u>Dispense as Written</u>**	**Print Name**	**Date**
Prescriber's Signature **<u>Substitution Permitted</u>**	**Print Name**	**Date**

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