

# Leqembi Referral Form

Fax completed form to: 833-908-1122



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
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. <b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed    Other <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other
<b>Pre-Medications:</b>	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 <b>Note:</b> Obtain MRI prior to 5 <sup>th</sup> , 7 <sup>th</sup> and 14 <sup>th</sup> 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 \_\_\_\_\_  
 Dispense as Written    Print Name    Date

Prescriber's Signature \_\_\_\_\_  
 Substitution Permitted    Print Name    Date



ACHC ACCREDITED

