

# Leqembi Referral Form



Fax Completed Form To:

Phone:

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height:                      Weight:	<input type="checkbox"/> Male <input type="checkbox"/> 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		
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical) <input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results <input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates) <input type="checkbox"/> Line access documentation/verification if applicable <input type="checkbox"/> Baseline and most recent MRI results (within the past year)		
<input type="checkbox"/> Imaging to confirm presence of amyloid beta pathology via MRI or PET scan <input type="checkbox"/> APOE ε4 Carrier Status <input type="checkbox"/> Documentation of mild cognitive impairment <input type="checkbox"/> 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 <input type="checkbox"/> Other <b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>		
PRESCRIPTION ORDERS		
<b>Anaphylaxis Kit:</b> <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other		
<b>Pre-Medications:</b> Per prescribing information: Pre-medications of antihistamine, corticosteroid and analgesic is recommended (Check all that apply) <input type="checkbox"/> Acetaminophen _____mg PO _____minutes prior to infusion <input type="checkbox"/> Solu-Medrol _____mg IV infusion _____minutes prior to infusion <input type="checkbox"/> Diphenhydramine _____mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV infusion _____minutes prior to infusion <input type="checkbox"/> Other		
<b>Supply Orders:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No   If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> Leqembi	<input type="checkbox"/> 10mg/kg IV in 250mL 0.9% Normal Saline <input type="checkbox"/> gravity --OR-- <input type="checkbox"/> 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.	_____
<input type="checkbox"/> OTHER		_____
<i>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.</i>		

Prescriber's Signature                      Print Name                      Date  
 Dispense as Written

Prescriber's Signature                      Print Name                      Date  
 Substitution Permitted



ACHC ACCREDITED

