

Leqembi Referral Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

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: ☐ 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		
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 baseline MRI, and again prior to 3 rd , 5 th , 7 th , and 14 th infusion. MRI results must be cleared by MD in order to proceed to next infusion. After 18 months: ☐ D/C therapy ☐ Continue 10 mg/kg every 4 weeks ☐ Transition to 360 mg SC once weekly	_____
☐ OTHER		_____
<i>By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.</i>		

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date