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: (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 baseline MRI, and again prior to 3rd, 5th, 7th, and 14th 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		_____

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.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

AME Leqembi Referral Form 7.31

ameritaiv.com

THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

ACHC ACCREDITED
PCAB ACCREDITED Compounding Pharmacy