ALZHEIMER'S THERAPY

FAX: 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Leqembi (lecanemab):
☐ 10mg/kg IV every 2 weeks
☐ 10mg/kg IV every 4 weeks (after 18 months of treatment, patient can transition to q 4 weeks*)

- *Patients may transition to every 4 weeks after 18 months or remain on every 2 weeks
- MRIs should be performed at baseline and prior to the 3rd, 5th, 7th, and 14th infusion
- HOLD infusion if MRI is not performed at indicated interval

Kisunla (donanemab):
☐ Initial start:
☐ Infusion 1: 350mg IV at week 0
☐ Infusion 2: 700mg IV at week 4
☐ Infusion 3: 1050mg IV at week 8
☐ Infusion 4 and beyond: 1400mg at week 12 and every 4 weeks thereafter

☐ Maintenance: 1400mg IV every 4 weeks

☐ Other:_____

- Protocol pre-medication (if no contraindications): acetaminophen 500mg PO and loratadine 10mg PO
- MRIs should be performed at baseline and prior to the 2nd, 3rd, 4th, and 7th infusion
- HOLD infusion if MRI is not performed at indicated interval

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:_____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg ☐ 1000mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:
☐ OK to use

Dx:

☐ Alzheimer's Disease, unspecified (G30.9)
☐ Other Alzheimer's Disease (G30.8)
☐ Mild cognitive impairment due to Alzheimer's Disease (G31.84)
- AND -
☐ Encounter for clinical registry program (Z00.6)) **Medicare required**
☐ Alzheimer's Disease with Early Onset (G30.0)
☐ Alzheimer's Disease with Late Onset (G30.1)

Other:_____ ICD-10: _____

PRESCRIBER SIGNATURE: x

Date (Valid for 1 year):

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

REQUIRED INFORMATION

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results

☐ MRI within 1 Year
☐ Confirmed presence of amyloid pathology (+CSF or amyloid PET scan)
☐ Cognitive Assessment Score: ☐ MMSE_____, ☐ MoCA_____, ☐ CDR_____ (Attach results)
☐ Functional Assessment Score: ☐ FAQ _____, ☐ FAST_____, ☐ Other_____ (Attach results)
☐ ApoE4 Testing
☐ Patient has been provided ARIA Risk counselling
☐ CMS Registry Confirmation Email (Medicare & Medicare Advantage required)
https://qualitynet.cms.gov/alzheimers-ced-registry/submission
☐ Does the patient have objective impairment in episodic memory as evidenced by a memory test (i.e., Free & Cued, Wechsler, etc) ?
☐ Yes ☐ No (BCBS required)
☐ Is the patient on therapeutic anticoagulation/antiplatelet therapy?
☐ Yes ☐ No (if yes , please note therapy & dose_____