ALZHEIMER'S THERAPY

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx: **Patient Name:** **Patient Weight:** kg **DOB:**

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
☐ Other: _____

☐ Tylenol _____mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl_____mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol

☐ OK to use

Dx:

☐ Alzheimer's Disease, unspecified (G30.9)
☐ Alzheimer's Disease with Early Onset (G30.0)
☐ Other Alzheimer's Disease (G30.8)
☐ Alzheimer's Disease with Late Onset (G30.1)
☐ Mild cognitive impairment due to Alzheimer's Disease (G31.84)

- AND -

☐ Encounter for clinical registry program (Z00.6)) **Medicare required**

Physician Signature **NPI #:** **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.

PHYSICIAN INFORMATION

Physician Name: **Clinic:**

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Required Documentation

☐ *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 yest, please note therapy & dose_____