

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)

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)

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**

***Lab Results**

MRI within 1 Year

Cognitive Assessment Score:

Functional Assessment Score:

***Insurance attached**

***Clinical progress notes**

Confirmed presence of amyloid pathology (+CSF or amyloid PET scan)

MMSE_____

FAQ_____

***Diagnosis(supporting)**

***Medication list**

MoCA_____

FAST_____

***History & Physical**

***Other Test Results**

CDR_____ (Attach results)

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_____)