

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:

*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

CMS Registry Confirmation Email (Medicare & Medicare Advantage required)

Patient has been provided ARIA Risk counselling

<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_____)