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
MRIs has performed at ☐ baseline, prior to ☐ the 5th infusion, ☐ the 7th infusion, ☐ the 14th infusion

- HOLD infusion if MRI is not performed at indicated interval
- REQUIRED: **Medicare & Medicare Advantage patients** must be registered with CMS prior to treatment
https://qualitynet.cms.gov/alzheimers-ced-registry/submission

Kisunla (donanemab):

☐ Initial start: 700mg IV every 4 week for 3 doses, then 1400mg IV every 4 weeks thereafter
☐ Maintenance: 1400mg IV every 4 weeks
MRIs has performed at ☐ baseline, prior to ☐ the 2nd infusion, ☐ the 3rd infusion, ☐ the 4th infusion, ☐ the 7th infusion

- HOLD infusion if MRI is not performed at indicated interval
- REQUIRED: **Medicare & Medicare Advantage patients** must be registered with CMS prior to treatment
https://qualitynet.cms.gov/alzheimers-ced-registry/submission

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)

☐ 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_____