TwelveStone Health Partners

Fax Referral To:(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

LEQEMBI ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER (Note: Only one stage of treatment may be ordered at a time)

☐ Stage 1 (Infusions #1-4)

✓ Leqembi 10mg/kg IV every two weeks x 4 doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

✓ MRI of brain within one year prior to first infusion.

✓ Date of MRI: _____

☐ By checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET.

☐ Stage 2 (Infusions #5 and #6)

✓ Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #5. I have reviewed the results and clear patient to proceed with infusions #5 and #6.

☐ Stage 3 (Infusions #7-13)

✓ Leqembi 10mg/kg IV every two weeks x 7 doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #7. I have reviewed the results and clear patient to proceed with infusions #7 through #13.

☐ Stage 4 (Infusions #14 and beyond)

✓ Leqembi 10mg/kg IV every two weeks x ____doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #14. I have reviewed the results and clear patient to proceed with infusions #14 and beyond as ordered aboce

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: _____325mg _____500mg _____650mg
- ☐ Loratadine: _____10mg
- ☐ Cetirizine: _____10mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Ibuprofen: _____200mg _____400mg _____600mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: _____4mg _____8mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Methylprednisolone: _____125mg
- ☐ Hydrocortisone: _____100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date