TwelveStone Health Partners

Fax Referral To:(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

TwelveStone HEALTH PARTNERS™

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: ______________

✓ I confirm that Beta Amyloid Pathology has been confirmed via CSF, PFT or other ______________.

✓ I confirm that ApoE4 status has been addressed either through testing or through informed risk vs. benefit and shared decision making with patient.

☐ 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:

✓ 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:

✓ 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:

✓ 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 above.

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