

LEQEMBI ORDER FORM

Date: _____	ICD-10 Code: _____	<p style="text-align: center;">Therapy Status</p> <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

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)

<input type="checkbox"/> Stage 1 (Infusions #1-4) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x 4 doses. Each infusion to be given over one hour. <p style="text-align: center;">Required Documentation to Initiate this Phase:</p> <input checked="" type="checkbox"/> MRI of brain within one year prior to first infusion. <input checked="" type="checkbox"/> Date of MRI: _____ <input checked="" type="checkbox"/> I confirm that Beta Amyloid Pathology has been confirmed via CSF, PET or other _____ <input checked="" type="checkbox"/> I confirm that ApoE4 status has been addressed either through testing or through informed risk vs. benefit and shared decision making with patient.	<input type="checkbox"/> Stage 2 (Infusions #5 and #6) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour. <p style="text-align: center;">Required Documentation to Initiate this Phase:</p> <input checked="" type="checkbox"/> 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.	<input type="checkbox"/> Stage 3 (Infusions #7-13) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x 7 doses. Each infusion to be given over one hour. <p style="text-align: center;">Required Documentation to Initiate this Phase:</p> <input checked="" type="checkbox"/> 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.	<input type="checkbox"/> Ongoing (Infusions #14 and beyond) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x _____ doses. Each infusion to be given over one hour. <p style="text-align: center;">Required Documentation to Initiate this Phase:</p> <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> Ongoing MRI monitoring past dose 14 at the discretion of the ordering provider.
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PRE-MEDICATIONS

<p>Oral</p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: _____ 10mg <input type="checkbox"/> Cetirizine: _____ 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p>IV</p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: _____ 125mg <input type="checkbox"/> Hydrocortisone: _____ 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber _____ _____	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____ _____	Substitution Allowed: _____ _____
Prescriber Name _____ Date _____	Prescriber Name _____ Date _____

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (615) 278-3350

Email: intake@12stonehealth.com

Toll Free: (844) 893-0012



Medicare patients require a CMS National Patient Registry entry. If you would like for TwelveStone to complete the registry, please provide the following information:

Clinical Diagnosis: MCI due to AD Mild AD Dementia
Date of Diagnosis: _____

ONE of the Tests Below Required to Confirm Amyloid Pathology:

Amyloid PET Scan: Positive Negative Not Performed
Date of Amyloid PET Scan: _____

OR

CSF Test: Positive Negative Not Performed
Date of CSF Test: _____

OR

Name of Other Amyloid Test: _____
Result of Other Amyloid Test: Positive Negative
Date of Other Amyloid Test: _____

ONE Cognitive Test Required:

MoCA Score: _____
Name of Other Cognitive Test: _____

OR

Other Cognitive Test Score: _____
Date of MoCA Score or Other Cognitive Test: _____

ONE Functional Test Required:

FAQ Score: _____
Name of Other Functional Test: _____

OR

Other Functional Test Score: _____
Date of FAQ Score or Other Functional Test: _____
Is there evidence of significant ARIA-E? Yes No
Date of ARIA-E Test: _____
Is there evidence of significant ARIA-H? Yes No
Date of ARIA-H Test: _____

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