

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

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LEQEMBI ORDER FORM

Patient Name: _____	ICD-10 Code: _____	Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Date of Birth: _____	Allergies: _____	
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 #1-2) ✓ Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour. Required Documentation to Initiate this Phase: ✓ MRI of the brain within 1 year prior to first infusion has been completed and results reviewed. Date of MRI: _____ Physician's Signature: _____ ✓ I confirm that Beta Amyloid Pathology has been confirmed via CSF, PET 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.	<input type="checkbox"/> Stage 2 (Infusions #3 and #4) ✓ 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 completed MRI of the brain, results have been reviewed and is clear to proceed with stage 2 infusions. Date of MRI: _____ Physician's Signature: _____	<input type="checkbox"/> Stage 3 (Infusions #5-6) ✓ 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 completed MRI of the brain, results have been reviewed and is clear to proceed with stage 3 infusions. Date of MRI: _____ Physician's Signature: _____	<input type="checkbox"/> Stage 4 (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 completed MRI of the brain, results have been reviewed and is clear to proceed with stage 4 infusions. Date of MRI: _____ Physician's Signature: _____	<input type="checkbox"/> Stage 5 (Infusions #14 and beyond) <input type="checkbox"/> Leqembi 10mg/kg IV every two weeks x _____ doses. Each infusion to be given over one hour. <input type="checkbox"/> Leqembi 10mg/kg IV every FOUR weeks x _____ doses. Each infusion to be given over one hour. Required Documentation to Initiate this Phase: ✓ I confirm that patient has completed MRI of the brain, results have been reviewed and is clear to proceed with stage 5 infusions. Date of MRI: _____ Physician's Signature: _____ ✓ Ongoing MRI monitoring past dose 14 at the discretion of the ordering provider.
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PRE-MEDICATIONS

Oral <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: _____	IV <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) • 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)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature _____	Date _____
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