

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

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**LEQEMBI ORDER FORM**

Date: _____	ICD-10 Code: _____	Therapy Status <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 #1-2) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour. Required Documentation to Initiate this Phase: <input checked="" type="checkbox"/> MRI of brain within one year prior to first infusion. <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 #3 and #4) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour. Required Documentation to Initiate this Phase: <input checked="" type="checkbox"/> I confirm that patient has undergone MRI of brain before dose #3. I have reviewed the results and clear patient to proceed with infusions #3 and #4.	<input type="checkbox"/> Stage 3 (Infusions #5-6) <input checked="" type="checkbox"/> Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour. Required Documentation to Initiate this Phase: <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 through #6.	<input type="checkbox"/> Stage 4 (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. Required Documentation to Initiate this Phase: <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 and #13.	<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: <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**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)**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

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.

Dispense as Written:

Substitution Allowed:

Prescriber Signature _____

Date _____

Prescriber Signature _____

Date _____