LEQEMBI (lecanemab) ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: ________________________________ DOB: ________________ Phone: _________________________

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Treatment Date: _______________________

MEDICAL INFORMATION

Patient Weight: ___________ lbs./kg. **(required)** Allergies: ____

Diagnosis:

- ☐ **Alzheimer's Disease w Early Onset (ICD-10:G30.0)**
- ☐ **Alzheimer's Disease w Late Onset (ICD-10: G30.1)**
- ☐ **Other Alzheimer's Disease (ICD-10: G30.8)**
- ☐ **Alzheimer's Disease, unspecified (ICD-10: G30.9)**
- ☐ **Mild Cognitive Impairment (ICD-10: G31.84)**

THERAPY ORDER

Leqembi: 10 mg/kg IV every 2 weeks for: (please select one)

- ☐ First 5 doses
- ☐ 6 months
- ☐ 1 year
- ☐ Other: ___________________________

- **MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusions**
- **HOLD INFUSION IF MRI IS NOT PERFORMED AT INDICATED INTERVAL**

ADDITIONAL REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ **Patient enrolled in the CMS National Patient Registry (Medicare and Medicare Advantage required)**
Issue number: _________________________ Date of registry enrollment: _______________________________

☐ **Confirmed presence of amyloid pathology.** Attach results: Amyloid PET scan OR +CSF (cerebrospinal fluid)

☐ **MRI of the brain** (within 1 year) – attach results

☐ **Cognitive assessment scores** (list all available, attach results):

☐ **MMSE:** Score ____________ Date of assessment ____________________

☐ **Functional assessment score: ______________ (attach results)**

☐ **Does the patient have objective impairment in episodic memory as evidenced by a memory test (i.s., Fred and Cued, Wechsler, etc.)? **BCBS required**** ☐ Yes ☐ No

☐ **Is the patient on therapeutic anticoagulant therapy?** ☐ Yes ☐ No

PROVIDER INFORMATION

Provider Name: ____________________________ Signature: ________________________ Date: ___________________

Provider NPI: ___________________________ Phone: __________________________ Fax: _________________________

Contact Person: ________________________________