ALZHEIMER'S THERAPY INFUSION 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 with Early Onset ICD-10 code: G30.0
- ☐ Alzheimer's Disease with Late Onset ICD-10 code: G30.1
- ☐ Other Alzheimer's Disease ICD-10 code: G30.8
- ☐ Alzheimer's Disease, unspecified ICD-10 code: G30.9
- ☐ Mild cognitive impairment, so stated ICD-10 code: G31.84
- ☐ Encounter for clinical registry program ICD-10 code: Z00.6 **Medicare required***

THERAPY ORDER

LEQEMBI (lecanemab):

- ☐ 10 mg/kg every 2 weeks
- ☐ 10 mg/kg every 4 weeks (after 18 months of treatment, patient can transition to q 4 weeks*)
  - Patients may transition to every 4 weeks after 18 months or remain on every 2 weeks
  - MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusion
  - HOLD infusion if MRI is not performed at indicated interval

KISUNLA (donanemab):

- ☐ Initial Start: Infusion 1: 350 mg IV at week 0
  Infusion 2: 700 mg IV at week 4
  Infusion 3: 1050 mg IV at week 8
  Infusion 4 and beyond: 1400 mg IV at week 12 and every 4 weeks thereafter
- ☐ Maintenance: 1400 mg IV every 4 weeks
- ☐ Other: _____
  - MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th, and 7th infusion
  - HOLD infusion if MRI is not performed at indicated interval

Refill for: ☐ **1 year** ☐ **Other:** _____

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR ALZHEIMER'S THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ Other medical necessity: _____

REQUIRED ADDITIONAL INFORMATION

- ☐ **Patient enrolled in the CMS National Patient Registry (Medicare & Medicare Advantage required)**
  Issue number: _____ Date of registry enrollment: _____
  - ☐ Provide copy of CMS national patient registry confirmation
- ☐ **Confirmed presence of amyloid pathology**
  Attach results: Amyloid PET scan OR +CSF (positive cerebrospinal fluid)
- ☐ **MRI of the brain (within 1 year) – attach results**
- ☐ **Cognitive assessment scores (list all available, attach results):**
  - ☐ **MMSE:** Score: _____ Date of assessment: _____
  - ☐ **MoCA:** Score: _____ Date of assessment: _____
  - ☐ **CDR** Score: _____ Date of assessment: _____
  - ☐ **Other**: Score: _____ Date of assessment: _____
- ☐ **Functional assessment score: _____ (attach results)**
  Assessment Name: ☐ FAQ ☐ FAST ☐ Other: _____ Assessment Date: _____
- ☐ **Include labs and/or test results for at least one of the following:**
  - ☐ Genotype testing for ApoE4
  - ☐ ApoE4 genetic testing has NOT been completed. Provider has counselled the patient on how testing for ApoE4 status informs the risk of developing ARIA and the patient has shared decision-making to initiate treatment
- ☐ **Does the patient have objective impairment in episodic memory as evidenced by a memory test (BCBS required)**
  ☐ Yes ☐ No
- ☐ **Is the patient on therapeutic anticoagulation/antiplatelet therapy?** ☐ Yes ☐ No
  If yes, please note therapy and dose: _____

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance