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 <u>after 18 months</u> or remain on every 2 weeks
  - MRIs should be performed at baseline & prior to the 3rd, 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: ______________________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

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

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ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION