ACTIVE infusions

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: _____

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

Date of Birth

Primary Phone Number

Alternate Phone Number

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

Relationship to Patient

Emergency Contact Phone

Emergency Contact Email

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

Relationship to Patient

Subscriber Date of Birth

Subscriber Member ID

Insurance Company

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 ID Number

NOTES / ADDITIONAL INFORMATION