Prairie Ridge HEALTH
Inspired by you

Patient Name:		DOB:
Phone number:	Allergies:	Pt wt (kg):

INFUSION SERVICES: LEQEMBI

Fax this form and a cover sheet to 920.306.8652 and call 920.623.7602

PRIOR AUTHORIZATION

☐ Prior Authorization Completed Prior Auth #: _____ Start Date: _____ End Date: _____

☐ *(*Required *for patients covered by Medicare or Medicare Advantage)* I attest that this patient is enrolled in a CMS approved registry for Alzheimer's Disease.
Name of Registry or Clinical Trial: _____ Submission #: _____ NCT#: 06058234

DIAGNOSIS

☐ G30.0 Alzheimer's Disease, Early Onset	☐ F02.80 Dementia without Behavioral Disturbance
☐ G30.1 Alzheimer's Disease, Late Onset	☐ F02.81 Dementia with Behavioral Disturbance
☐ G30.8 Other Alzheimer's Disease	☐ Other: _____ (ICD-10 code) _____ (Description)
☐ G30.9 Alzheimer's Disease, Unspecified	**NOTE: G30.X codes require secondary F02.8X code**
☐ G31.81 Mild Cognitive Impairment, So Stated	

PRESCRIBER MUST INDICATE THE FOLLOWING REQUIREMENTS HAVE BEEN MET

☐ Cognitive Assessment Used: _____ Date: _____ Result: _____

☐ ApoE ε4 Genetic Test Date: _____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier ☐ Declined

MEDICATION ORDER

NOTE: Only one stage of treatment may be ordered at a time

☐ Stage 1 (Infusions #1-4)	☐ Stage 2 (Infusions #5-6)	☐ Stage 3 (Infusions #7-13)	☐ Stage 4 (Infusions #14+)
Leqembi 10mg/kg IV every 2 weeks x 4 doses. Each infusion to be given over one hour.	Leqembi 10mg/kg IV every 2 weeks x 2 doses. Each infusion to be given over one hour.	Leqembi 10mg/kg IV every 2 weeks x 7 doses. Each infusion to be given over one hour.	Leqembi 10mg/kg IV every 2 weeks x __ doses. Each infusion to be given over one hour.
Required Documentation to Initiate this Phase: MRI of brain within one year prior to first infusion Date of MRI: _____ ☐ By Checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET.	**Required Documentation to Initiate this Phase:** ☐ By Checking this box, I confirm that the patient has undergone MRI of brain before dose #5. Date of MRI: _____ I have reviewed the results and clear patient to proceed with infusion #5-6.	**Required Documentation to Initiate this Phase:** ☐ By Checking this box, I confirm that the patient has undergone MRI of brain before dose #7. Date of MRI: _____ I have reviewed the results and clear patient to proceed with infusion #7-13.	**Required Documentation to Initiate this Phase:** ☐ By Checking this box, I confirm that the patient has undergone MRI of brain before dose #14. Date of MRI: _____ I have reviewed the results and clear patient to proceed with infusion #14+.

LABS

	Lab Test	Frequency	ICD 10 DX
#1			
#2			

OTHER ORDERS

By signing this order form you agree to the following orders, unless otherwise noted.
✓Hold infusion and notify provider if patient reports: Headache, Dizziness, Nausea, Vision Changes, New or Worsening Confusion
✓Place peripheral IV and maintain per hospital policy
✓PICC or Central line maintenance per hospital policy
✓Ordering provider will arrange placement of PICC line for infusions with a duration of 7 days or longer
✓May initiate Cathflo protocol for occluded PICC/Central line followed by chest x-ray PRN for verification of placement
✓Infusion/allergic reactions may be managed per facility protocol

Physician Name (print):	Physician Signature:
Date:	Phone number:

If patient is acutely ill at the time of the planned service, they will be evaluated by the Prairie Ridge Health ER and their planned therapy may be canceled based on their condition. If patient declines an evaluation by our ER physician, the planned service will be canceled, and they will be asked to follow-up with the ordering provider.