Leqembi® (lecanemab) Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per VIVO protocols.

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ Every _____
☐ CMP ☐ At each dose ☐ Every _____
☐ CRP ☐ At each dose ☐ Every _____
☐ Other _____

REQUIRED DIAGNOSIS (Select one)

☐ Mild Cognitive Impairment Due to Alzheimer's Disease– G31.84

☐ Early Onset Alzheimer's Disease – G30.00

☐ Late Onset Alzheimer's Disease – G30.1

☐ Other Alzheimer's Disease – G30.8

☐ Alzheimer's Disease unspecified-G30.9

LEQEMBI THERAPY ADMINISTRATION

☐ 10mg/kg IV every 2 weeks

MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusion

REQUIRED DOCUMENTATION:

**** Patient must be registered with CMS prior to treatment https://qualitynet.cms.gov/alzheimers-ced-registry****

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Cognitive Assessment Score _____ (MMSE 22-30, CDR-GS 0.5 or 1)**
☐ **MRI Within 1 Year**
☐ **Confirmed presence of amyloid pathology (*+CSF or amyloid PET scan*)**
☐ **CMS Registry Confirmation**
☐ **ApoE ε4 Testing**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Colorado: 303-418-4679
☐ Florida: 904-930-4211
☐ Texas: 469-340-0044
☐ Nevada: 702-489-5744
☐ New Jersey: 609-955-3711
☐ Ohio: 216-400-0674
☐ Oklahoma: 918-770-4421
☐ Massachusetts: 203-724-4838
☐ Pennsylvania: 215-399-9244
☐ New York: 203-724-4838
☐ Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

Revision Date 12/2023