Leqembi® (lecanemab) Referral Form

VIVO infusion

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 – G30.0

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 ___

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