

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 _____

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>****

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

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

Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

**Email Specialty Referrals to:
info@specialtyinfusion.com**

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