Leqembi® (lecanemab) Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Referral ☐ Referral 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 Digits 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 _____

PREMEDICATIONS (please write in): _____

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

☐ 10 mg/kg IV every 4 weeks (after 18 months of treatment only)

** For ongoing treatment, MRIs are required at baseline & prior to the 5th, 7th, and 14th infusion**

REQUIRED DOCUMENTATION:

**** Medicare patients 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 20-28, CDR-GS 0.5 or 1)**
☐ **MRI Within 1 Year**
☐ **Confirmed presence of amyloid pathology**
☐ **CMS Registry Confirmation ALZH-_____ (Medicare and Medicare Advantage only)**
☐ **ApoE ε4 Testing (if available)**
☐ **Patient has been provided ARIA Risk counseling**

*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**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below **Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679
Connecticut: 203-724-4838
Florida: 904-930-4211
Massachusetts: 781-202-1629
Michigan: 833-957-2188
Minnesota: 763-290-0903
Nevada: 702-489-5744
New Jersey: 609-955-3711
New York: 800-540-1852
Ohio: 216-400-0674
Oklahoma: 918-770-4421
Pennsylvania: 215-399-9244
Texas: 469-340-0044
Virginia: 804-500-5941
Wisconsin: 414-600-5383

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