

Leqembi® (lecanemab) Referral Form



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:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

NURSING

☒ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

<input type="checkbox"/> CBC	at each dose	every _____
<input type="checkbox"/> CMP	at each dose	every _____
<input type="checkbox"/> 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

Provider Name (Print)

Provider Signature

Date

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

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

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

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