

# Leqembi® (Icanemab) Referral Form



Preferred Clinic (select one):

## PATIENT INFORMATION

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:    |

## STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

CBC every \_\_\_\_\_  
CMP 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 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. \*\*Referral is valid for one year unless otherwise noted\*\*

Email Referrals To: [referrals@vivoinfusion.com](mailto: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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