Leqembi® (lecanemab) 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 w/ diff every _____

☐ CMP every _____

☐ OTHER _____

PREMEDICATIONS (please write in below):

_____

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

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

LEQEMBI ADMINISTRATION

☐ 10mg/kg IV every 2 weeks

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

** MRIs are required at baseline & prior to the 3rd, 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**

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

Have a Question? Call (720) 902-4111

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

Order is valid for one year unless otherwise noted.

Revision Date 01/2026