

# 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.

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## LEQEMBI ADMINISTRATION

10mg/kg IV every 2 weeks  
10 mg/kg IV every 4 weeks (after 18 months of treatment only)

**Post infusion line flush with 20mL NS**

**\*\* 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

<b>Email Referrals To: <a href="mailto:referrals@vivoinfusion.com">referrals@vivoinfusion.com</a> OR Fax Below</b>			<b>Have a Question? Call (720) 902-4111</b>	
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.\*\*

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