# Leqembi® Referral Form

**Fax Referral To:**
**833-271-9979**

CONTINUUM Health

## PREVIOUS ADMINISTRATION

**Please provide the following information:** Last Infusion Date: _____ Next Infusion Date: _____

## Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

***Primary Diagnosis:***

_____ Encounter for examination for normal comparison and control in clinical research program

***Secondary Diagnosis:***

_____ Alzheimer's disease with early onset
_____ Alzheimer's disease with late onset
_____ Alzheimer's disease, unspecified
_____ Other: _____

**Please attach the following:**

• Insurance Card • H&P • Demographics • Medication List • Tried/Failed Therapies • Medicare Registry #_____
• MRI within 1 year • CSF or PET Scan Showing Amyloid Pathology • Cognitive Assessment & Score • Most Recent Labs

## Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

## Medication Order

***Medication:*** **Leqembi® (lecanemab)**

***Referring provider is responsible for obtaining an MRI prior to the 5th, 7th, and 14th infusions**

Leqembi 10mg/kg IV (calculated dose_____mg) every 2 weeks
Other: _____

First Dose: Y ◉ N ◯ Refill x12 months unless otherwise noted: _____

***Line Use/Care Orders:***

☐ Start PIV/ACCESS CVC ☐ Flush device per Continuum Health Infusion Center Protocol
☐ Other Flush Orders: Please fax other line care orders if checking this box

***ADVERSE REACTION & ANAPHYLAXIS ORDERS***

☐ Administer acute infusion and anaphylaxis medications per Continuum Health anaphylaxis protocol.
☐ Other: Please fax other reaction orders if checking this box

**By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)**
**By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.**

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date