TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

LEQEMBI ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER (Note: Only one stage of treatment may be ordered at a time)

☐ Stage 1 (Infusions #1-4)

✓ Leqembi 10mg/kg IV every two weeks x 4 doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

✓ MRI of brain within one year prior to first infusion.

✓ Date of MRI: _____

✓ I confirm that Beta Amyloid Pathology has been confirmed via CSF, PET or other _____.

✓ I confirm that ApoE4 status has been addressed either through testing or through informed risk vs. benefit and shared decision making with patient.

☐ Stage 2 (Infusions #5 and #6)

✓ Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

✓ I confirm that patient has undergone MRI of brain before dose #5. I have reviewed the results and clear patient to proceed with infusions #5 and #6.

☐ Stage 3 (Infusions #7-13)

✓ Leqembi 10mg/kg IV every two weeks x 7 doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

✓ I confirm that patient has undergone MRI of brain before dose #7. I have reviewed the results and clear patient to proceed with infusions #7 through #13.

☐ Ongoing (Infusions #14 and beyond)

✓ Leqembi 10mg/kg IV every two weeks x____doses. Each infusion to be given over one hour.

Required Documentation to Initiate this Phase:

✓ I confirm that patient has undergone MRI of brain before dose #14. I have reviewed the results and clear patient to proceed with infusions #14 and beyond as ordered above.

✓ Ongoing MRI monitoring past dose 14 at the discretion of the ordering provider.

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: _____325mg _____500mg _____650mg
- ☐ Loratadine: _____10mg
- ☐ Cetirizine: _____10mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Ibuprofen: _____200mg _____400mg_____600mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: _____4mg _____8mg
- ☐ Diphenhydramine: _____25mg_____50mg
- ☐ Famotidine: _____20mg_____40mg
- ☐ Methylprednisolone: _____125mg
- ☐ Hydrocortisone: _____100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

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Medicare patients require a CMS National Patient Registry entry. If you would like for TwelveStone to complete the registry, please provide the following information:

Clinical Diagnosis: ☐ MCI due to AD ☐ Mild AD Dementia
Date of Diagnosis: _____

ONE of the Tests Below Required to Confirm Amyloid Pathology:

Amyloid PET Scan: ☐ Positive ☐ Negative ☐ Not Perfomed
Date of Amyloid PET Scan: _____

OR

CSF Test: ☐ Positive ☐ Negative ☐ Not Perfomed
Date of CSF Test: _____

OR

Name of Other Amyloid Test: _____
Result of Other Amyloid Test: ☐ Positive ☐ Negative
Date of Other Amyloid Test: _____

ONE Cognitive Test Required:

MoCA Score: _____
Name of Other Cognitive Test: _____

OR

Other Cognitive Test Score: _____
Date of MoCA Score or Other Cognitive Test: _____

ONE Functional Test Required:

FAQ Score: _____
Name of Other Functional Test: _____

OR

Other Functional Test Score: _____
Date of FAQ Score or Other Functional Test: _____
Is there evidence of significant ARIA-E? ☐ Yes ☐ No
Date of ARIA-E Test: _____
Is there evidence of significant ARIA-H? ☐ Yes ☐ No
Date of ARIA-H Test: _____

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