**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 Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date

V 03.05.25