OKLAHOMA INFUSION SERVICES

Leqembi Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax all required documents listed on page 2

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ Alzheimer's Disease with Early Onset (ICD-10 code: G30.0)
☐ Alzheimer's Disease with Late Onset (ICD-10 code: G30.1)
☐ Alzheimer's Disease, unspecified (ICD-10 code: G30.9)
☐ Mild cognitive impairment, so stated (ICD-10 code: G31.84)
☐ Other Alzheimer's Disease (ICD-10 code: G30.8)

Medicare Required Diagnosis

☒ Encounter for clinical registry program (ICD-10 code: Z00.6),

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____

Lab Orders

☐ Labs: _____ Lab Frequency:_____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Leqembi

Dose: 10 mg/kg every 2 weeks
Refill for: ☐ 6 months ☐ 1 year ☐ Other: _____ (cannot be greater than 1 year)

- MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusion
- HOLD infusion if MRI is not performed at indicated interval

Pre-Medication Orders

☐ Solu-Cortef 50-100mg SIVP
☐ Tylenol tablet 500-1000mg PO PRN
☐ Benadryl 25mg PO PRN
☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____
Prescriber's Signature: Date:

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Preferred Location

☐ **Edmond**
1701 Renaissance Blvd, Ste 110
Edmond, OK 73013

☐ **Elk City**
2406 Bell Ave
Elk City, OK 73644

☐ **Enid**
825 E Owen K Garriott Rd
Enid, OK 73701

☐ **Norman**
808 Wall St
Norman, OK 73072

☐ **Stillwater**
605 S Orchard St
Stillwater, OK 74074

☐ **Tulsa**
9322 E 41st St
Tulsa, OK 74145

www.okinfusion.com

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REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL FOR LEQEMBI

☐ Include signed and completed order (MD/prescriber to complete page 1)
☐ Include patient demographic information and insurance information
☐ Include patient's medication list
☐ Supporting clinical notes (H&P) to support primary diagnosis
☐ Other medical necessity: _____

Patient enrolled in the CMS National Patient Registry

Registry number: _____ Date of registry enrollment: _____
Provide copy of CMS national patient registry confirmation https://qualitynet.cms.gov/alzheimers-ced-registry/submission.
(Provider must submit follow-up information in 6 months to CMS Registry)

Imaging and pathology results

☐ Amyloid PET scan OR +CSF (cerebrospinal fluid) – attach results
☐ MRI of the brain (within 1 year) - attach results

Cognitive assessment scores (minimum of one required, attach results)

☐ MMSE - Score _____ Date of assessment _____
☐ MoCA - Score _____ Date of assessment _____
☐ CDR - Score _____ Date of assessment _____
☐ MiniCog - Score _____ Date of assessment _____

BCBS Insurance Only - Memory Test (minimum of one required, attach results)

Does the patient have objective impairment in episodic memory as evidenced by a memory test (i.e, Free and Cued, Wechsler, etc.)? ☐ Yes ☐ No

Functional Assessment (minimum of one required, attach results)

☐ FAQ - Score _____ Date of assessment _____
☐ FAST - Score _____ Date of assessment _____

Include labs and/or test results for the following:

☐ Genotype testing for ApoE4
- OR –
☐ ApoE4 genetic testing has NOT been completed.
Provider has counselled the patient on how testing for ApoE4 status informs the risk of developing ARIA and the patient has shared decision-making to initiate Leqembi therapy.

Anticoagulation/Antiplatelet Therapy

☐ Is the patient on therapeutic anticoagulation/antiplatelet therapy? ☐ Yes ☐ No
If yes, please note therapy and dose: _____
Patient currently taking an anticoagulant; must be provided with counseling that the combined use of Leqembi with anti-coagulant drugs may increase the risk of cerebral macro-hemorrhage and prescriber attests that the patient has shared in decision-making to initiate Leqembi therapy.