Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Encounter for examination for normal comparison an control in clinical research program **(Medicare/Medicare Advantage only: select this code and a secondary code(s) below)** — ICD 10 Code: Z00.6

☐ Alzheimer's disease with early onset — ICD 10 Code: G30.0

☐ Mild Cognitive Impairment, So stated — ICD 10 Code: G31.84

☐ Other: _____ — ICD 10 Code: _____

G30.X CODES BELOW REQUIRE SECONDARY F02.8x DIAGNOSIS CODE - PLEASE SELECT ONE FROM EACH COLUMN

	➔	**Secondary**
☐ G30.1 Alzheimer's disease late onset		☐ F02.80 Dementia witihout behavioral disturbance
☐ G30.8 Other Alzheimer's disease		☐ F02.81 Dementia with behavioral disturbance
☐ G30.9 Alzheimer's disease, unspecified		

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ CMS Registry Number _____ Date of Enrollment_____
*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)
☐ Labs and Tests supporting primary diagnosis
☐ Baseline MRI within 1 year

List Tried & Failed Therapies, including duration of treatment:
1)

Prescriber must indicate that the following requirements have been met (provide supporting documentation)

☐ Beta Amyloid Pathology Confirmed via:
↳ ☐ Amyloid PET Scan Date: _____ Result: _____
OR ☐ CSF Analysis Date: _____ Result: _____
OR ☐ Blood Plasma Date: _____ Result: _____

☐ Cognitive Assessment Used: _____ Date: _____ Result: _____

☐ ApoE ϵe4 Genetic Test - Date: _____ Result: _____ ☐ Omozygote ☐ Heterozygote ☐ Noncarrier

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt: BMI:

Initial Dosing ☐ J0174 Leqembi 10mg/kg every 2 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

Pre-Infusion: ☑ Confirm baseline MRI results prior to initiation of treatment
☑ Confirm MRI completed and reviewed by prescriber prior to the 5th, 7th, and 14th treatment
☑ Hold infusion and notify provider if patient reports: headache, dizziness, nausea, vision changes, or new/worsening confusion.
Post-Infusion: ☑ Educate patient/care partner to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
Ph. 217-342-7500 Fax 217-342-7499

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1247

INFUSION ORDERS - LEQEMBI (lecanemab-irmb)

Clinics Scan to: Physician Orders