Hy-Vee health
INFUSION CARE

LEQEMBI® (LECANEMAB) Referral Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Referral Status: New Referral Updated Order Order Renewal

Patient Name: ______ **DOB:** ______ **Phone:** ______

Patient Address: ______ **Patient Email:** ______

NKDA Allergies: ______ **Weight (lbs/kg):** ______ **Height:** ______

ICD-10 Code (required): ______ **ICD-10 Description:** ______ **Last Treatment Date:** ______ **Last 4 SSN:** ______

Provider Information

Referral Coordinator Name: ______ **Referral Coordinator Email:** ______

Ordering Provider: ______ **Referring Practice Name:** ______

Practice Address: ______ **City:** ______ **State:** ______ **Zip:** ______

NURSING

☑ Infusion to be administered per Hy-Vee Health Protocols.

LABORATORY ORDERS

CBC At each dose Every ______

CMP At each dose Every ______

CRP At each dose Every ______

CSF or Plasma Biomarkers ______

PREMEDICATIONS

Acetaminophen (Tylenol) 500 mg / 650 mg / 1000 mg PO

Cetirizine (Zyrtec) 10 mg PO

Loratadine (Claritin) 10 mg PO

Diphenhydramine (Benadryl) 25 mg / 50 mg / PO / IV

Methylprednisolone (Solu-Medrol) 40 mg / 125 mg IV

Hydrocortisone (Solu-Cortef) 100 mg IV

Other: ______

Dose: ______ Route: ______

Frequency: ______

LEQEMBI THERAPY ADMINISTRATION

10 mg/kg/ IV every 2 weeks

MRI'S RESULTS

Baseline

Prior to 5th Dose

Prior to 7th Dose

Prior to 14th Dose

ARIA - E / ARIA - H

Notes: ______

****MRIs should be performed at baseline and prior to the 5th, 7th and 14th infusion****

REQUIRED DOCUMENTATION:

****Patient must be registered with CMS priror to treatment https://qualitynet.cms.gov/alzheimers-ced-registry****

Not applicable for patients with commercial insurance.

Progress Notes Supporting DX

Cognitive Assessment Score ______

Confirmed Presence of Amyloid Pathology (*+CSF or Amyloid PET Scan*)

CMS Registry Number ______

APOE Status Mild Moderate

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: ______ **Signature:** ______ **Date:** ______

Provider NPI: ______ **Phone:** ______ **Fax:** ______ **Contact Person:** ______

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ______

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX Phoenix, AZ Other ______

HY-VEEHEALTHINFUSION.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

© Hy-Vee Health 2023