

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629 **E** specialty@hqrx.com

DATE: _____ NEXT TREATMENT DATE: _____

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____ Phone _____ Date of Birth _____ Provider Name _____
 Practice Name _____ NPI# _____ Phone _____ Fax _____ Contact Person _____

MEDICAL INFORMATION

- DIAGNOSIS**
- Alzheimer's Disease with Early Onset (ICD-10 code: G30.0)
 - Alzheimer's Disease with Late Onset (ICD-10 code: G30.1)
 - Other Alzheimer's Disease (ICD-10 code: G30.8)
 - Alzheimer's Disease, unspecified (ICD-10 code: G30.9)
 - Mild cognitive impairment, so stated (ICD-10 code: G31.84)
- AND -**
- Encounter for clinical registry program (ICD-10 code: Z00.6), **Medicare required**

Patient Weight: _____ **kg** (required) Allergies: _____

THERAPY ORDER

- Leqembi** (lecanemab)
- 10 mg/kg IV every 2 weeks
 - 10 mg/kg IV every 4 weeks (after 18 months of treatment, patient can transition to q 4 weeks)
- Patients may transition to every 4 weeks after 18 months or remain on every 2 weeks
 - MRIs should be performed at baseline and prior to the 3rd, 5th, 7th, and 14th infusion
 - HOLD infusion if MRI is not performed at indicated interval

- Kisunla** (donanemab)
- (choose one)
- Initial start:
 - Infusion 1: 350 mg IV at week 0
 - Infusion 2: 700 mg IV at week 4
 - Infusion 3: 1,050 mg IV at week 8
 - Infusion 4 and beyond: 1,400 mg at week 12 and every 4 weeks thereafter
 - Maintenance: 1,400 mg IV every 4 weeks
 - Other: _____
- MRIs should be performed at baseline and prior to the 2nd, 3rd, 4th, and 7th infusion
 - HOLD infusion if MRI is not performed at indicated interval

Pharmacist may substitute brand based on product availability. If needed, dose to be rounded to nearest whole vial.

Premedication orders: Tylenol <input type="checkbox"/> 1000mg <input type="checkbox"/> 500mg PO, please choose one antihistamine:	
<input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Quztytir 10mg IVP	
Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other: _____	
Lab orders: _____	Frequency: <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____
<input type="checkbox"/> Yearly TB testing QFT (optional) Required labs to be drawn by: <input type="checkbox"/> HealthQuest <input type="checkbox"/> Referring physician	

- Anaphylactic Reaction Orders:**
- Epinephrine (based on patient weight)
 - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5–10 minutes x1
 - 15–30kg (33–66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5–10 minutes x1
 - Diphenhydramine: Administer 25–50mg orally OR IV (adult)
 - NS 0.9% 500mL IV bolus as needed (adult)
 - Refer to physician order or institutional protocol for pediatric dosing

- Flush orders:**
- NS 1–20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.

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PATIENT INFORMATION

Patient Name _____ Date of Birth _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- 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 (Medicare & Medicare Advantage required)**
 - Issue Number _____ Date of registry enrollment _____
 - Provide copy of CMS national patient registry confirmation
<https://qualitynet.cms.gov/alzheimers-ccd-registry/submission>
 - Confirmed presence of amyloid pathology**
 - Attach results: Amyloid PET scan OR +CSF (cerebrospinal fluid)
 - MRI of the brain (within 1 year) - attach results**
 - Cognitive assessment scores (list all available, attach results):**
 - MMSE:** Score _____ Date of assessment _____
 - MoCA:** Score _____ Date of assessment _____
 - CDR:** Score _____ Memory box: Score _____ Date of assessment _____
 - Other: _____ Score _____ Date of assessment _____
 - Functional assessment score: _____ (attach results)**
 - Assessment Name: FAQ FAST Other: _____ Assessment Date: _____
 - 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
 - Does the patient have objective impairment in episodic memory as evidenced by a memory test (i.e., Free and Cued, Wechsler, etc.)? (BCBS required)** Yes No
 - Is the patient on therapeutic anticoagulation/antiplatelet therapy?** Yes No
- If yes, please note therapy and dose: _____

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please **fax** all information to **(832) 500-8629**