ALZHEIMER'S THERAPY
Referral Form

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		**DOB**		**Gender**	Male ☐ Female ☐	**Weight**	____lbs ☐ kg ☐
SSN		**Phone**		**Allergies**			
Address		**City**		**State**		**Zip Code**	
Patient Status	☐ **New to Therapy** ☐ **Continuing Therapy**			**Next Treatment Date**			

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

Primary Insurance		**Name of the Insured**		**Relationship**	
Member ID#		**Group #**		**Insurance Phone #**	
Secondary Rx Carrier		**Rx ID #**		**Rx Group #**	

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**

Therapy Orders

Leqembi: ☐ 10mg/kg IV every 2 weeks
(lecanemab)

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

Kisunla: ☐ 700mg IV every 4 week for 3 doses, then 1400mg IV every 4weeks thereafter
(donanemab)

☐ Maintenance: 1400mg IV every 4 weeks

- MRIs should be performed at baseline & prior to the 2nd, 3rd, 4th, and 7th infusion
- HOLD infusion if MRI is not performed at indicated interval

Refill for: ☐ 6 months ☐ 1 year ☐ Other: _____

Additional orders: _____

Lab orders: _____ **Lab frequency:** _____

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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: _____

Required

☐ **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

☐ **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 thepatient 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:If yes, please note therapy and dose:_____

Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Date

Prescriber's Signature

X_____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance