

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back)

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-
 Clinical research investigation (ICD-10 code: Z00.6), **Medicare primary**

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

Allergies: _____

THERAPY ORDER

Leqembi: 10mg/kg IV every 2 weeks

Refill for: 6 months 1 year Other: _____

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

Additional orders: _____

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

Required labs to be drawn by Paragon Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

Opt out of Paragon selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

View our locations here:



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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 required)**
Submission reference #: _____ <https://qualitynet.cms.gov/alzheimers-ced-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)**
Name of Assessment: FAQ FAST Other: _____
Date of assessment: _____
- 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: _____

Paragon Healthcare 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 (855) 889-2946 or call (877) 365-5566 for assistance

PARAGONHEALTHCARE.COM