PARAGON HEALTHCARE

A Carelon Company

ALZHEIMER'S THERAPY INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Medication Orders	Refills
Leqembi (lecanemab)	☐ 10mg/kg IV every 2 weeks ☐ 10mg/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 & prior to the 3rd, 5th, 7th, and 14th infusion • HOLD infusion if MRI is not performed at indicated interval	☐ x 1 year ☐ _____
Kisunla (donanemab)	☐ Initial start: Infusion 1: 350mg IV at week 0 Infusion 2: 700mg IV at week 4 Infusion 3: 1,050mg IV at week 8 Infusion 4 and beyond: 1,400mg at week 12 and every 4 weeks thereafter ☐ Maintenance: 1400mg IV every 4 weeks ☐ Other: _____ • Protocol pre-medication (if no contraindications): acetaminophen 500mg PO & loratadine 10mg PO • 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	☐ x 1 year ☐ _____

Additional orders: _____

Lab orders: _____ **Frequency:** _____

Required labs to be drawn by ☐ Paragon ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR ALZHEIMER'S THERAPY

PATIENT INFORMATION

Name: DOB:

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 current medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis - Including tried/failed medications.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **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-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)**

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: _____