

**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-**

- 
- Encounter for clinical registry program (ICD-10 code: Z00.6),
- Medicare required**

 Patient Weight: \_\_\_\_\_ **kg** (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**
**Leqembi:**  10mg/kg IV every 2 weeks

(lecanemab)

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

**Kisunla:**  Initial start: 700mg IV every 4 week for 3 doses, then 1400mg IV every 4 weeks thereafter  
 Maintenance: 1400mg IV every 4 weeks

(donanemab)

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

 Refill for:  6 months  1 year  Other: \_\_\_\_\_

**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:



**PATIENT INFORMATION:**

Patient 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 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  
<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: \_\_\_\_\_
- iADRS score: \_\_\_\_\_ (attach results) 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: \_\_\_\_\_

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