PARAGON HEALTHCARE

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

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 5th, 7th, and 14th infusion
- HOLD infusion if MRI is not performed at indicated interval

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Kisunla:
(donanemab)

- ☐ Initial start: 700mg IV every 4 week for 3 doses, then 1400mg IV every 4 weeks thereafter
- ☐ 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

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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:

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR ALZHEIMER'S THERAPY

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:__________

☐ **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

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