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

Patient Name: _____ DOB: _____ Phone: _____

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

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: (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 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:

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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