

# LEQEMBI IQLIK REFERRAL FORM



FAX REFERRAL TO: +1(844) 277-0049

PHONE: +1(844) 650-5802

## 1 PATIENT'S INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  MALE  FEMALE  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_ SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## 2 INSURANCE (Please attach If Available a copy of the Patients' insurance card(s) Front/ Back)

Primary Insurance: \_\_\_\_\_ Policy No: \_\_\_\_\_ Group: \_\_\_\_\_  
 Primary RX Insurance: \_\_\_\_\_ ID No: \_\_\_\_\_ RX GRP: \_\_\_\_\_ RX BIN: \_\_\_\_\_ RX PCN: \_\_\_\_\_

## 3 DIAGNOSIS AND CLINICAL INFORMATION

Is the patient already on Leqembi IQLIK Subcutaneous Injection?  Yes  No If YES, Last Treatment Date: \_\_\_\_\_

If NO, Has the Patient completed 18 months of IV therapy prior to starting Leqembi IQLIK SC ?  Yes  No Last Dose Given: \_\_\_/\_\_\_/\_\_\_

### Diagnosis (ICD-10) and Patient Clinical Information:

G30.0: Alzheimer's disease with early onset  G30.1: Alzheimer's disease with late onset  G30.8: Other Alzheimer's disease  
 G30.9: Alzheimer's disease, unspecified  G31.84: Mild cognitive impairment of uncertain or unknown etiology  
 Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

### Imaging to confirm presence of amyloid beta pathology:

Baseline and most recent MRI results (within the past year) Original MRI Diagnosis Date: \_\_\_/\_\_\_/\_\_\_ Recent MRI Date: \_\_\_/\_\_\_/\_\_\_  
 or Baseline and most recent PET scan: Original PET Scan Diagnosis Date: \_\_\_/\_\_\_/\_\_\_ Recent PET Scan Date: \_\_\_/\_\_\_/\_\_\_

APOE ε4 Carrier Status:  Carrier  Non-carrier

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request:

CMP  CBC w/diff  MRI  PET Scan  APOE ε4 Carrier Status

## 4 PRESCRIPTION INFORMATION

Access:  Subcutaneous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILL
<input type="checkbox"/> Leqembi IQLIK	360 mg/1.8 mL	Administer 1 Auto-injector (360 mg) Subcutaneously once weekly. Note: Start Leqembi IQLIK SC maintenance Dose 1 week AFTER last IV infusion maintenance dose.	Quantity: (x4) Auto-injectors	Refills: 1 YEAR

### NURSING/ INFUSION SUPPLIES:

NURSING: Skilled nursing visit for the initial dose, training/education of patient or caregiver on administration of Leqembi IQLIK auto-injector.

## 5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: \_\_\_\_\_ Title:  MD  DO  ND  PA  APRN NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

DISPENSE AS WRITTEN  BRAND MEDICALLY NECESSARY  DO NOT SUBSTITUTE  May Substitute /  Product Selection Permitted /  Substitution Permissible  
 NO SUBSTITUTION /  DAW /  MAY NOT SUBSTITUTE

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

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