LEQEMBI REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

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 Subcutaneouse 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:

Diagnosis (ICD-10) 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: ☐ Homozygous ☐ Heterozygous ☐ 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: ☒ Intravenous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILL
☐ **Leqembi**	200 mg Or 500 mg	☐ **Initial Infusion:** Administer 10 mg/Kg (_____ kg) Intravenously over approximately 1 hour twice monthly for 18 months.	Quantity: **Q.S**	Refills: **1 YEAR**
		☐ **Maintenance Infusion:** Two weeks after initial 18 months of infusions, Administer 10 mg/Kg (_____ kg) IV over approximately 1 hour every _____ Weeks.	Quantity: **Q.S**	Refills: **1 YEAR**

Access: ☒ Subcutaneous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILL
☐ **Leqembi IQLIK**	☐ 360 mg	**Maintenance Dose:** Administer 1 Auto-injector **(360 mg)** SC once weekly. **Note: *Start Leqmbi IQLIK SC maintenance Dose 1 week AFTER last IV infusion maintenance dose.***	Quantity: **(x4) PFS**	Refills: **1 YEAR**

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ SoluMedrol® **(IV)**	Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min.	Quantity: **Q.S**	Refills: **PRN**
☐ Loratadine **(PO)**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ EPINEPHRINE **(vial or autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☐ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial**	Refills: **PRN**
☐ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **Q.S**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☐ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.

☐ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.

FLUSHING PROTOCOL: ☐ Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

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**
☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE**

Prescriber's Signature: _____ **Date:** _____

☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**

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.

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to info@ivsolutionsrx.com and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*