LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Alzheimer's Disease with Early Onset ICD 10 Code: G30.0
☐ Mild Cognitive Impairment, So Stated ICD 10 Code: G31.84
☐ Other: _____ ICD 10 Code: _____

G30.x CODES BELOW REQUIRE SECONDARY F02.8x DIAGNOSIS CODE- PLEASE SELECT ONE FROM EACH COLUMN

→ **Secondary**

☐ Alzheimer's Disease with Late Onset ICD 10 Code: G30.1
☐ Other Alzheimer's Disease ICD 10 Code: G30.8 ☐ F02.80 Dementia without behavioral Disturbances
☐ Alzheimer's Disease, unspecified ICD 10 Code: G30.9 ☐ F02.81 Dementia with Behavioral Disturbances

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number	☐ Clinical/Progress notes (must be within 1 year) ☐ Baseline MRI Results *Pt may be required to submit a pregnancy test prior to treatment

☐ Beta Amyloid Pathology Confirmed via:
☐ Amyloid PET Scan Date:_____ Results:_____
Or ☐ CFS Analysis Date: _____ Results: _____
Or ☐ Blood Plasma Date: _____ Results: _____
☐ Cognitive Assessment Used: _____ Date:_____ Results: _____
☐ ApoE Genetic Test: Date: _____ Results: _____ ☐ Omozygote ☐ Heterozygote ☐ Non Carrier
☐ ☐Completion of CMS approved CED registry: CED Submission Date: _____ Submission Number: _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders

Dosing	☐ J0174 Leqembi 10mg/kg every 2 weeks

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

ADDITIONAL ORDERS/INFORMATION

Pre Infusion:	☐ Confirm baseline MRI results prior to initiation of treatment
	☐ Confirm MRI completed and reviewed by prescriber prior to 5th, 7th and 14th treatment
	☐ Hold infusion and notify PCP if patient reports: Headache, Dizziness, nausea, vision changes, or new/worsening confusion
Post infusion:	☐ Educate patient/care partner to report: Headache, Dizziness, nausea, vision changes, or new/worsening confusion

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen 500mg PO PRN ☐ CBC Date: _____
☐ Benadryl 25mg PO or IV ☐ CMP Date: _____
☐ Other: _____ ☐ Other: _____ Date:_____

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – LEQEMBI (LECANEMAB-IRMB)