BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

LEQEMBI (LECANEMAB)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.922.3656

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:
- ☐ Mild cognitive impairment, so stated (ICD-10 code: G31.84)
- ☐ 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)

Patient Weight: _____ **kg** (required)

Allergies: _____

THERAPY ORDER

Leqembi: 10mg/kg IV every 2 weeks

Refill for: ☐ 6 months ☐ 1 year ☐ Other: _____

MRIs should be performed at baseline & prior to the 5th, 7th, and 14th infusion

Additional orders:

Lab orders: _____ **Lab frequency:** _____

Required labs to be drawn by ☐ Biocare Infusion ☐ Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* 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 Biocare Infusion 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 LEQEMBI 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
  - ☐ Cognitive assessment score: _____

    Name of Assessment: _____ Date of assessment: _____
- ☐ Labs and/or diagnostics attached
  - ☐ MRI (within 1 year)
  - ☐ Confirmed presence of amyloid pathology (+CSF or amyloid PET scan)
- ☐ Other medical necessity: _____

Biocare Infusion 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 (470) 922-3656 or call (470) 377-6400 for assistance