Alzheimer's Referral Form

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PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Ht: _____ Wt: _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ NKDA ☐ Allergies: _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ ZIP: _____

REQUIRED INFORMATION FOR EITHER LEQEMBI AND KISUNLA

☐ Clinical notes confirming presence of amyloid pathology (amyloid PET scan or +CSF)

☐ Baseline brain MRI (within 1 year) prior to initiating treatment

Cognitive Test: ☐ MMSE or ☐ MoCA or ☐ Other: _____ Score: _____ Date: _____

Functional Test: ☐ FAQ or ☐ Katz ADLs or ☐ Other: _____ Score: _____ Date: _____

☐ APOe4 results (Please attach results, if possible. Required for some insurance plans)

MEDICATION ORDERS

ICD-10 Diagnosis Codes:

☐ **Kisunla:** ☑ Z00.6 ☐ G30.0 ☐ G31.84 ☐ **Leqembi:** ☑ Z00.6 ☐ G30.0 ☐ G31.84

☐ **New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

PRE-MEDICATION

☐ Acetaminophen1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP

Kisunla IV Orders, every 4 weeks

☐ Infusion 1: 350 mg
☐ Infusion 2: 700 mg
☐ Infusion 3: 1,050 mg
☐ Infusion 4 and beyond: 1400mg

☐ MRI prior to 2nd, 3rd, 4th and 7th infusion

☐ Refills: _____

Leqembi IV Orders, every 2 weeks

☐ Leqembi 10mg/kg IV

☐ MRI within approximately 1 week prior to 3rd, 5th, 7th, and 14th infusions

For patients on Leqembi for 18 months or longer

☐ Continue infusions every 2 weeks
☐ Maintenance infusions every 4 weeks

☐ Refills: _____

Sage Infusion Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name	Provider Signature	Date