CareMed
SPECIALTY PHARMACY

Faxed prescriptions can only be accepted from a prescribing practitioner.
e-prescribe - NPI# 1659380772 or NCPDP# 3306986

Pharmacy 877.227.3405
Fax 877.542.2731

Leqembi IQLIK Rx Referral Form

Patient Information (REQUIRED)

Patient Name:	Date of Birth:	Referral Date:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Authorized Contact:	Height: ft. in. Weight: lbs.	❑ Male ❑ Female
Patient Diagnosis & ICD-10:		
Allergies:		

Provider Information (REQUIRED)

Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervising Physician (if applicable):		

Please Attach

- ❑ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ❑ Recent office visit notes, history & physical, lab & pertinent procedure results
- ❑ Current medication list & list of prior medications tried and failed (with dates)
- ❑ Line access documentation/verification if applicable
- ❑ Baseline and most recent MRI results (within the past year)
- ❑ Imaging to confirm presence of amyloid beta pathology via MRI or PET scan
- ❑ APOE ε4 Carrier Status
- ❑ Documentation of mild cognitive impairment
- ❑ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines
- ❑ Prior authorization letter or any pertinent prior authorization information

Product	Prescription Information		Refills
❑ Leqembi IQLIK Initiation	❑ Inject 500mg (2x250mg/1.25ml pens) subcutaneously once weekly as directed	❑ Dispense #8 Leqembi IQLIK 250mg/1.25ml autoinjectors (28 day supply)	_____
❑ Leqembi IQLIK Maintenance	❑ Inject 360mg/1.8ml subcutaneously once weekly as directed	❑ Dispense #4 Leqembi IQLIK 360mg/1.8ml autoinjectors (28 day supply)	_____

Has the patient completed 18 months of Leqembi IV therapy? ❑ Yes ❑ No If Yes, when was last IV dose given? _____

By signing this form and utilizing our services, you are authorizing CareMed to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted