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 Rx Order 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
Is this a first dose? ❑ Yes ❑ No	If No, when was last dose given?_____	When is patient due for next dose? _____	
☐ Leqembi	☐ 10mg/kg Infuse 10mg/kg, total dose _____ via IV once every 2 weeks as directed **Note:** Obtain an MRI after 1, 2, 3, and 6 months of treatment. MRI results must be cleared by MD in order to proceed to next infusion.	☐ Dispense # _____ Vials of Leqembi 200mg ***-OR-*** ☐ Dispense # _____ Vials of Leqembi 500mg	_____
☐ OTHER			_____

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