Your Health, True Wealth

Alzheimer's Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
f: 818-882-8929

PATIENT INFORMATION

Patient Name		DOB	Contact Phone
Address	City	State	Zip
Gender ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐ Allergies		
ICD-10 code (required)		ICD-10 description	
Patient Status ☐ New to Therapy ☐ Continuing Therapy		Tried and failed meds ☐Yes ☐No If yes:	
Cognitive assessment score	Name of assessment	Date of assessment	
Labs/diagnostics attached: ☐ MRI (within 1 year)	☐ Confirmedpresenceofamyloidpathology (amyloid PET scan or +CSF)		

PRESCRIBER INFORMATION

Ordering Prescriber Practice		Prescriber NPI	
Name Practice Address		Phone	Fax
	City	State	Zip

REQUIRED DOCUMENTATION

☐Insurance Cards	☐History & Physical	☐Most Recent Labs	☐Medication List

ALZHEIMER'S TREATMENT PLAN

☐ Leqembi®
☐ Administer 10mg/kg IV every 2 weeks

☐ Other	Include dosage, frequency and any other special instructions.

☐ Refill for 1 year

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Northridge Pharmacy Specialty & Infusion's infusion protocol.
☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929

Prescriber Name (Print)	Prescriber Signature	Date