MIDLAND HEALTH

Beta Amyloid Confirmation and Lecanemab Treatment Order Form

Patient Name: _____ D.O.B: _____
Patient Phone #: _____ Patient Height: _____ Patient Weight (kg): _____
Patient's Care Giver Name: _____ Patient's Care Giver Phone #: _____
Reason for Exam: _____ ICD-10-CM Code: _____
Appt. Date: _____ Time: _____ Accession Number: _____
Date of Initial MRI Brain With and Without Contrast: _____
(Initial MRI Must Be Completed at Diagnostic Imaging Associates Within the Last 12 Months)

Appointment is Scheduled at (Location):

- ☐ DIA – Craddick Medical Office Building 400 Rosalind Redfern Grover Parkway Suite 110 (located next to MMH)
- ☐ DIA – Legends Park Office Building 5615 Deauville Blvd, Suite 110 (located near Scarborough Sports Complex)
- ☐ MMH Radiology – 400 Rosalind Redfern Grover Parkway
- ☐ MMH Infusion Center – 400 Rosalind Redfern Grover Parkway

BETA AMYLOID CONFIRMATION ORDER MRI/LP Preauthorization/Predetermination #: _____

- ☐ PETCT Amyloid Brain
  OR
- ☐ Lumbar Puncture (Patient must NOT be on blood thinners for the required hold time prior to exam date. Platelet Count & Coag Profile is needed within 30 days of exam. Please provide results or check mark lab below)

LABS:

- ☐ For Lumbar Pucture - Platelet Count / Coag Profile
- ☐ APOE4 (ARUP 2013341)
- ☐ Lumbar Puncture C.S. Fluids: Alzheimer's Disease Markers, CSF (ARUP 3017653 Phospho-Tau (181P) CSF/ Beta-Amyloid (1-42) CSF Ratio – ARUP Supply Kit #58810)

LECANEMAB TREATMENT PLAN ORDER

- ☐ Lecanemab Infusion Therapy – 10mg/kg IV every 2 weeks in Normal Saline 250ml every 2 weeks over at least 1 hour

Duration: 6 months ☐ 12 months ☐ Other: _____ ☐ (Order is good for 12 months - a new order will be required after 12 months)
Prior 5th, 7th and 14th Lecanemab Infusion, the provider must be called for approval.

Infusion Preauthorization/Predetermination #: _____ **CMS Registry (ALZH) #:** _____

- ☐ MRI Brain without Contrast – Prior to Infusion 5 **MRI Preauthorization/Predetermination #:** _____
- ☐ MRI Brain without Contrast – Prior to Infusion 7 **MRI Preauthorization/Predetermination #:** _____
- ☐ MRI Brain without Contrast – Prior to Infusion14 **MRI Preauthorization/Predetermination #:** _____

Provider Signature: _____ **Date:** _____
Provider Name Printed: _____ **Date:** _____

All Imaging Scheduling: 432-221-2300 Fax Request To: 432-221-4926

MMH Outpatient Treatment Center: 432-221-3900 Fax Request To: 432-221-3612