Texas Centers for Infectious Disease Associates Pharmacy
FORT WORTH / 1025 College Ave., Fort Worth, TX 76104
Email: tcidaintake@tcida.net
Phone: 817-336-1640 **Fax: 817-336-1643**
DALLAS / 3410 Worth St., Ste. 780, Dallas TX 75246

Patient Information	Prescriber Information
Patient name:	Prescriber name:
DOB: SSN:	DEA:
Address:	NPI License:
City: State: Zip:	Address:
Phone #:	City: State: Zip:
Gender: ☐Male ☐Female ☐Other	Phone: Fax:

Insurance Information: Complete entirely and fax front and back of patient's insurance card					
Primary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Secondary Insurance	Subscriber	ID:	Name of insurer:		Phone:
Prescription card:	Name of insurer:	ID:	BIN:	PCN:	Group:

ICD 10 and Diagnosis:	Patient History	
ICD 10:	Weight ☐KG ☐LB	Height ☐IN ☐CM
Diagnosis:	☐NKDA ☐Allergies:	Registry number: ALZH- _____

Provider Orders:					
	Drug	Dose	Route	Frequency	Therapy length
MEDICATION	☐ Leqembi	Initial dosing: 10mg/kg (_____mg)	IV	Q2 weeks	X 18 months
	☐ Leqembi	Maintenance dose 10mg/kg (_____mg)	IV	☐ Q2 weeks ☐ Q4 weeks	X 1 year
PRE-MEDICATION	☐Acetaminophen 325 mg PO ☐ Diphenhydramine 25 mg PO ☐ Diphenhydramine 25 mg IV ☐ Dexamethasone 4mg IVP ☐ Methylprednisolone 40mg IVP ☐ Other: _____				

MRI	
- Baseline brain MRI needed - Brain MRI must be provided prior to the 5th, 7th and 14th infusions.	***Please fax MRI report with MRI approval document to 817-336-1643 prior to the 5th, 7th and 14th infusion ***

Nursing: Evaluate and teach patient administration of IV ABX, provide IV-line dressing change weekly and PRN, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, dose IV antibiotics based on labs, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber signature: _____ Date: _____

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MRI Approval Document

Patients Name: _____

Patients DOB: _____

*Please fax or email MRI report with MRI approval document to 817-336-1643 or tcidaintake@ticda.net

prior to the 5th, 7th and 14th infusion *

☐ MRI Report

☐ MRI report reviewed and approval to infuse _____ insert infusion number} infusion

Prescriber signature: _____

Date: _____

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Referral check off

- **MD note**
  - Typical H&P with any pertinent information relating to the patient's diagnosis, condition and symptoms, if the patient has any history of ARIA (ARIA-E or ARIA-H)
- **Demographic sheet**
- **Last set of labs**
- **Confirmation of amyloid pathology**
  - Amyloid positron emission tomography (PET) scan
    - OR
  - Cerebrospinal fluid (CSF)
- **Cognitive assessment with a validated tool**
  - Clinical dementia rating (CDR) scale
    - OR
  - Mini-mental state exam (MMSE) score
    - OR
  - Montreal Cognitive assessment (MoCA)
- **Functional assessment with a validated tool**
  - The functional activities questionnaire (FAQ) score
- **Baseline MRI**
  - Subsequent MRI after 5th, 7th and 14th infusion
    - Each MRI will be faxed with MRI approval document