

## 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:  
p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

### PATIENT INFORMATION

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

### PRESCRIBER INFORMATION

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

### REQUIRED DOCUMENTATION

<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List
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### ALZHEIMER'S TREATMENT PLAN

<input type="checkbox"/> Leqembi® <input type="checkbox"/> Administer 10mg/kg IV every 2 weeks	
<input type="checkbox"/> Aduhelm® administer Aduhelm IV every 4 weeks as follow. (Select One Below) <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Initial dose w/ maintenance dosing.            1mg/kg for infusion 1 and 2            3mg/kg for infusion 3 and 4            6mg/kg for infusion 5 and 6            10mg/kg for infusion 7 and beyond         </div> <div> <input type="checkbox"/> Maintenance dosing.            10mg/kg         </div> </div>	
<input type="checkbox"/> Other	Include dosage, frequency and any other special instructions.
<input type="checkbox"/> 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

<input type="checkbox"/> Include premedication per Soleo's infusion protocol. <input type="checkbox"/> Other _____
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### LABORATORY ORDERS

<input type="checkbox"/> CBC every _____ <input type="checkbox"/> CMP every _____ <input type="checkbox"/> Other _____
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I authorize the above patient treatment and Soleo Health 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 Soleo Health at phone 844.575.1515,

Prescriber Name (Print)

Prescriber Signature

Date