



## Patient Referral for Monoclonal Antibody Treatment of Cognitive Impairment

### PATIENT INFORMATION

Patient name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Cell: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### REFERRING PROVIDER INFORMATION

Provider name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_


**To participate in monoclonal antibody treatment, the patient must meet the following criteria. Please carefully review each item and check each box to verify the patient meets each requirement.**

- Patient has mild cognitive impairment (MCI) or mild dementia
- Age 50-90 years (if under 50 years old, please refer to Neurology)
- Body Mass Index greater than 17 and/or equal to 35 kg/m<sup>2</sup>
- MMSE (Mini Mental Status Examination) > 21 or MoCa (Montreal Cognitive Assessment Test) > 16 or SLUMS (Saint Louis University Mental Status) > 16
- FAQ (Functional Activities Questionnaire) less than 15
- MRI completed in the past year with no other obvious cause of cognitive impairment, such as acute or chronic hemorrhages, amyloid angiopathy, tumors or strokes with clinically meaningful deficits (mild chronic small vessel disease is okay). CT is not acceptable as alternative as patient must be able to tolerate MRI for follow up.
- Absence of APOE4 homozygosity (ordered through LabCorp; insurance may not cover cost)
- Absence of coagulopathy – can't be taking NOAC or Warfarin; Platelet count > 100,000; Prothrombin Time (PT) < 14, Partial Thromboplastin Time (PTT) < 36, International Normalized Ratio (INR) < 1.3
- Absence of seizure disorder; multiple sclerosis; Parkinson's disease; malignancies requiring ongoing treatment; oxygen dependency; severe lung, heart (unstable angina, CHF NYHA Class 3 or 4), kidney (CKD 4 or on dialysis), or liver disease (cirrhosis); drug or alcohol abuse in the past year; rheumatologic or GI disease requiring immunosuppression; or life expectancy of less than 1 year.
- Patient has social support person with transportation

**PLEASE SEND 1) COPY OF PATIENT'S INSURANCE CARD 2) LAST TWO OFFICE VISIT NOTES AND 3) ANY LAB OR TEST RESULTS PERTAINING TO THE PATIENT DIAGNOSIS AND CRITERIA ABOVE**

REV 03.24

DO NOT WRITE IN THIS BOX



M-603

PATIENT INFORMATION LABEL