MARSHALL Health
A provider-based department of Cabell Huntington Hospital

INTERNAL MEDICINE

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/m2 (limits are only for Leqembi)
- ❑ 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

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REV 12.24

DO NOT WRITE IN THIS BOX

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PATIENT INFORMATION LABEL