



Patient Name: _____

Date of Birth: _____

Date of Service: _____

ANTI-AMYLOID THERAPY PATIENT AGREEMENT FORM

I understand that my medical provider at Norton Neuroscience Institute has recommended that I receive anti-amyloid therapy [Lecanemab (Leqembi) or Donanemab (Kisunla)] as part of my medical treatment, based upon my medical diagnosis and condition. By signing this form, I acknowledge, understand and agree to the following conditions to make my treatment with this therapy as safe and successful as possible.

Please initial:

_____ My medical provider has explained to me the nature and purpose of anti-amyloid therapy, as well as the benefits, potential risks, and possible side effects of the treatment. These potential risks include, but are not limited to, swelling/bleeding in the brain and infusion reactions.

_____ I agree that I understand the expectations of my provider and the Norton Neuroscience Institute regarding the importance of routine surveillance during the course of my anti-amyloid therapy.

_____ I agree to keep my routine office appointments with the Norton Neuroscience Institute. These routine visits commonly take place every 3 to 6 months, but may need to be scheduled more frequently as deemed appropriate by my provider.

_____ I agree to undergo MRI scans as frequently as deemed appropriate by my provider. I understand that this will typically include MRI scans before the 2nd, 3rd, 4th and 6th months of therapy. Additional MRI scans may be ordered by my medical provider if needed based upon my condition and symptoms or risk.

_____ I understand that an expert panel has recommended that thrombolytic/anticoagulant medications should not be used while I receive anti-amyloid therapy. I will notify my medical provider at Norton Neuroscience Institute if I am prescribed a thrombolytic/anticoagulant medication by a different medical provider, and I will inform my other medical providers that I receive anti-amyloid therapy. I will also notify my medical provider at Norton Neuroscience Institute if I am prescribed systemic monoclonal antibodies by a different medical provider as it may have an impact upon my ability to receive anti-amyloid therapy.

_____ I agree to notify my provider at Norton Neuroscience Institute of any changes in my health conditions, as well as any new medications I am prescribed by a different medical provider.

_____ I agree to navigation services through the Norton Healthcare. These services will help facilitate evaluation for and management of my anti-amyloid therapy.

_____ I understand that failure to comply with this Agreement may result in my provider and Norton Neuroscience Institute cancelling my anti-amyloid therapy.

Patient Signature _____

Date _____

Witness Signature _____

Date _____