Health Care Medical
Infusion Specialties
An Access Infusion Care Company

LEQEMBI (LECANEMAB-IRMB ORDERS)

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	NPI: _____
City, State, Zip: _____	Address: _____
Cell: _____ Email _____	City, State, Zip: _____
Height _____ Weight ____kg Last 4 of SSN: ____DOB:_____	Phone: _____ Fax: _____
Allergies:_____	Contact Person: _____

REFERRAL STATUS	
☐ New Referral	First dose? ☐ Yes ☐ No - Date of last infusion:_____
☐ Dose or Frequency Change	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other
☐ Continuation Order	

DIAGNOSIS	
☐ G30.0 Alzheimer's disease with early onset	Z00.6 Encounter for examination for normal comparison and control in clinical research program
☐ G30.1 Alzheimer's disease late onset	☐ F02.80 Dementia without behavioral disturbance
☐ G30.8 Other Alzheimer's disease	☐ F02.81 Dementia with behavioral disturbance
☐ G30.9 Alzheimer's disease, unspecified	☐ G31.84 Mild Cognitive Impairment due to Alzheimer's Disease

REQUIRED DOCUMENTATION	
This signed order form by the provider Patient demographics and insurance information H&P, labs, tests, and progress notes supporting diagnosis ApoE ε4 Genetic Test: Homozygote Heterozygote Noncarrier Date of test:_____	☐ Medicare beneficiaries: NCT registry number:_____ ☐ Date of brain MRI negative for ARIA: _____ ☐ Documentation of amyloid beta pathology by PET scan, CSF sample, or Plasma sample
SUBSEQUENT BRAIN MRI AND WRITTEN APPROVAL FROM ORDERING PROVIDER MUST BE OBTAINED PRIOR TO INFUSING 3RD,5TH, 7TH AND 14th INFUSION.	

PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity
Lecanemab-irmb (Leqembi)	10 mg/kg	New Start ☐ Infuse 10 mg/ kg IV in 0.9% 250 ml NS over 60 minutes every 2 weeks for months 0-12 (hold infusions 3, 5, & 7 for MRI results)	Qty: sufficient for weight-based doses Refill: 1 year
		Maintenance ☐ Infuse 10 mg/ kg IV in 0.9% 250 ml NS over 60 minutes every 2 weeks for months 13-18 (hold infusion 14 for MRI results) ☐ Infuse 10 mg/ kg IV in 0.9% 250 ml NS over 60 minutes every 4 weeks for months 19 and greater	Qty: sufficient for weight-based doses Refill: __ If not specified, order will be valid for 1 year from the date of signature
Observation		Observe patient for a minimum of 3 hours after the 1st infusion, 2 hours after the 2nd and 3rd infusion, then 30 minutes post subsequent infusions	

PREMEDICATIONS (administer 30 minutes prior to infusion)
☐ Acetaminophen: ☐ 650 mg ☐ 1000 mg PO
☐ Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO

PIV: Flush with 3–10 mL of 0.9% sodium chloride before and after the infusion PICC/Midline: Flush 10 mL 0.9% NS before/after, then 3 mL Heparin 10 units/mL final flush Port: Flush 10 mL 0.9% NS before/after, then 5 mL Heparin 100 units/mL final flush Post-Infusion: Use 50 ml 0.9% NS bag to flush residual priming volume	RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration RN to flush and lock VAD/CVAD per company protocol

EMERGENCY MEDICATION

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Print, complete, and fax completed form to: (769) 233-8051

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Administer the following medications as needed for infusion-related reactions per company protocol:
Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.
Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO_2 95–100%.

Prescriber Signature X: _____ X:

_____

Product Substitution Permitted: _____ Date: _____ Dispense as Written: _____ Date: _____

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