

Leqembi™ (Lecanemab-irmb)

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

Medicare Registry # _____

DIAGNOSIS:

- G30.0 Alzheimer's Disease, Early Onset
- G30.1 Alzheimer's Disease, Late Onset
- G30.8 Other Alzheimer's disease
- G30.9 Alzheimer's disease, unspecified
- G31.84 Mild Cognitive Impairment, So Stated

G30.X codes require secondary F02.8X code BELOW:

- F02.80 Dementia without behavioral disturbance
- F02.81 Dementia with behavioral disturbance

PRESCRIBER MUST INDICATE THE FOLLOWING REQUIREMENTS HAVE BEEN MET (PLEASE PROVIDE DOCUMENTATION):

- Beta Amyloid Pathology Confirmed Via:
 - Amyloid PET Scan Date: _____
 - OR**
 - CSF Analysis Date: _____ Result: _____
- Cognitive Assessment Used:
 - Date: _____ Result: _____
- ApoE E4 Genetic Test:
 - Date: _____
 - Result: Homozygote Heterozygote Noncarrier

PRE-INFUSION:

- Confirm baseline MRI results prior to initiation of treatment.
- Confirm MRI completed and reviewed by prescriber prior to the 5th, 7th, and 14th treatment.
- Measure and record weight prior to each treatment to determine dose.
- Hold infusion and notify provider if patient reports:
 - Headache
 - Vision changes
 - Dizziness
 - New or worsening confusion
 - Nausea

MEDICATION:

- Administer LEQEMBI 10 mg/kg intravenously over at least 60 minutes.
- Dilute required volume of lecanemab-irmb in 250 ml 0.9% sodium chloride and infuse using a terminal low-protein binding 0.2-micron in-line filter.
- If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

TREATMENT FREQUENCY:

- Schedule treatments every two weeks (at least 14 days apart).

POST-INFUSION:

- Educate patient/care partner to report headache, dizziness, nausea, vision changes, or new/worsening confusion.
- Fax treatment notes to provider at number below.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

 Provider Name (Print) Provider Signature Date