Leqembi

(lecanemab-irmb)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Alzheimer's Disease with Early Onset (G30.0)
☐ Alzheimer's Disease with Late Onset (G30.1)
☐ Other Alzheimer's Disease (G30.8)
☐ Alzheimer's Disease, unspecified (G30.9)

AND

☐ Mild cognitive impairment (G31.84)

☑ Encounter for clinical registry program (Z00.6) **Medicare required.**

PRESCRIPTION

Leqembi (lecanemab-irmb) ☐ 10 mg/kg IV every 2 weeks ☐ 10 mg/kg IV every 4 weeks (optional dosing after 18 months)

- Patients may transition to every 4 weeks after 18 months or may remain on every 2 weeks
- MRIs should be performed at baseline & prior to the 3rd, 5th, 7th, and 14th infusion
- HOLD infusion if MRI is not performed at indicated interval

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Tried/failed therapies
- Baseline MRI within 1 year
- CSF or PET Scan showing Amyloid Pathology
- Cognitive Assessment & Score
- Functional Assessment & Score
- Medicare Registry #

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol.
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☑ Per infusion center protocol: Tylenol 650 mg, cetirizine or loratadine 10 mg PO before each dose.

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.