Infusion Solutions Inc.
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LEQEMBI (lecanemab-irmb) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____

ALLERGIES:_____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: LEQEMBI **(lecanemab-irmb)** ❒NO ❒YES LAST DOSE DATE: _____

DIAGNOSIS:_____ ICD 10 CODE(S):_____

MEDICATION ORDERS

DOSE/FREQUENCY: (dose on actual body weight) Maintenance orders are valid for 1 year. For a shorter duration, indicate here: _____

❒ **Initial regimen**: 10 mg/kg IV every 2 weeks for the first 18 months
❒ **Maintenance regimen option 1**: Continue 10 mg/kg IV every 2 weeks
❒ **Maintenance regimen option 2**: 10 mg/kg IV every 4 weeks
❒ **Maintenance regimen option 3**: 360 mg Sub-Q once weekly
❒Other: _____

MRI MUST be obtained AND interpreted baseline & prior to 3rd, 5th, 7th, & 14th infusion of Leqembi to monitor for ARIA. Infusion Solutions will NOT infuse these doses until MRI results interpreted as ARIA negative are obtained.

If the prescriber wishes to proceed with a Leqembi infusion prior to obtaining an MRI or after obtaining an MRI positive for ARIA, they must send an order indicating such approval.

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify provider.
- Observe patient for at least 15 minutes after completion of therapy.

LABS

LAB ORDERS:

❒ _____

LAB FREQUENCY:

❒ _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- ApoE ε4 test results
- Documentation indicating amyloid beta pathology
- Baseline MRI with interpretation performed within the past year

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Documentation of any hypersensitivity to polysorbate 80

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution)

PRESCRIBER SIGNATURE (dispense as written)

PRINT NAME (FIRST AND LAST)

DATE