Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

ThrIVewell™ INFUSION

Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

LEQEMBI MEDICATION ORDER

Date: _____

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal ☐ Discontinuation Order

■ **Diagnosis**

☐ G31.84 Mild cognitive impairment, so stated
☐ G30.0 Alzheimer's with early onset (at <65y/o)
☐ G30.1 Alzheimer's with late onset (at 65y/o)
☐ G30.8 Other Alzheimer's disease

■ **Details Needed for Therapy**

Supporting documentation of patient's neurological history, including relevant tests and laboratory results.
- Documentation of the presence of amyloid beta pathology.
- Brain MRI from within the past year. Brain MRI must be provided prior to the 5th, 7th and 14th infusions.
- There is a risk of Amyloid Related Imaging Abnormalities (ARIA). Testing for and clinical evaluation regarding ARIA before and during therapy, and the decision on whether to suspend therapy, remains the sole responsibility of the ordering provider. **The MRI reports and orderin provider written evaluations must be provided before the start of each round of therapy.**

■ **IV Premedication Order (optional)** *IV pre-medications to be administered 15 minutes prior to start of the infusion treatment.*

☐ Diphenhydramine _____mg ☐ Dexamethasone _____mg ☐ Methylprednisolone _____mg

■ **Leqembi (lecanemab-irmb) Medication Order** **Patient's height in ft/in:** _____ **Patient's weight in lbs:** _____

Only one course can be selected per order form.

☐ 10mg/kg IV every 2 weeks for treatments number 1 – 4
☐ 10mg/kg IV every 2 weeks for treatments number 5 – 6
☐ 10mg/kg IV every 2 weeks for treatments number 7 – 13
☐ 10mg/kg IV every 2 weeks for treatments number 14 – 20

Medication shall be added to a 250ml 0.9% NaCl infusion bag and infused over 1 hour. The IV line shall have a 0.2 micron in-line filter attached. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

ORDERING PROVIDER

Provider's Signature: X_____ **Name:** _____ **Date:** _____

Address: _____

Phone: _____ **Fax:** _____ **NPI #:** _____ **License:** _____

Best Contact Person in Office: _____ **Direct Phone Line to Contact Person:** _____

■ **STANDARD DOCUMENTATION TO INCLUDE:**

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.