

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



LEQEMBI MEDICATION ORDER Date: _____

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

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal <input type="checkbox"/> Discontinuation Order	

■ Diagnosis

- | | |
|---|---|
| <input type="checkbox"/> G31.84 Mild cognitive impairment, so stated | <input type="checkbox"/> G30.1 Alzheimer's with late onset (at 65y/o) |
| <input type="checkbox"/> G30.0 Alzheimer's with early onset (at <65y/o) | <input type="checkbox"/> 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.*

- | | | |
|--|--|---|
| <input type="checkbox"/> Diphenhydramine _____mg | <input type="checkbox"/> Dexamethasone _____mg | <input type="checkbox"/> 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.

- | | |
|---|---|
| <input type="checkbox"/> 10mg/kg IV every 2 weeks for treatments number 1 – 4 | <input type="checkbox"/> 10mg/kg IV every 2 weeks for treatments number 7 – 13 |
| <input type="checkbox"/> 10mg/kg IV every 2 weeks for treatments number 5 – 6 | <input type="checkbox"/> 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.