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ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

LEQEMBI (lecanemab-irmb) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Phone:	Preferred Location:	

PROVIDER INFORMATION

Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Office Contact:	Address:	
Email (required):		

REFERRAL STATUS

Check One: ☐New Referral ☐Referral Renewal ☐Updated Order ☐Transfer of care – Date of last infusion/Next due date

LEQEMBI:
Leqembi is indicated for the treatment of Alzheimer's disease (AD). Treatment with Leqembi should be initiated if patients with mild cognitive impairment (MCI) or mild dementia stage of disease, the population in which treatment was initiated in the clinical trials.

Please note MRIs to assess for ARIA are required **prior to doses 3, 5, 7, and 14 and must be sent to Thrivewell** with an updated order for the appropriate dose set marked in order for patients to be cleared to proceed with treatment. Failure to provide the required MRI report at least 24hrs prior to the patient's scheduled appointment may result in delay in care for the patient.

■ **Diagnosis ICD-10**
Check one:
☐ G31.84 Mild Cognitive impairment, so stated
☐ G30.0 Alzheimer's Disease with early onset
☐ G30.1 Alzheimer's Disease with late onset
☐ G30.8 Other Alzheimer's Disease
☐ G30.9 Alzheimer's Disease, unspecified

■ **Premeds**
Select all that apply:
☐ Acetaminophen _____mg PO (recommended for first 6 doses)
☐ Cetirizine 10mg PO
☐ Diphenhydramine (check all that apply)
___25mg ___50mg ___PO ___IV
☐ Methylprednisolone _____mg IV
☐ SoluCortef _____mg IV
☐ Other: _____

PATIENT WEIGHT
_____ lbs.
_____ kg

Therapy Administration and Dosing (supplied as 200mg/2mL or 500mg/5mL vial)
All patients will be weighed prior to every infusion and medication will be administered according to that weight, diluted in 0.9% NS IVPB over 1 hour.

ONLY ONE DOSE SET CAN BE SELECTED AND A NEW ORDER WILL BE REQUIRED FOR EACH SUBSEQUENT SET

☐ Doses #1 – 2: 10mg/kg IV every 2 weeks
☐ Doses #3 – 4: 10mg/kg IV every 2 weeks
☐ Doses #5 – 6: 10mg/kg IV every 2 weeks
☐ Doses #7 – 13: 10mg/kg IV every 2 weeks
☐ Doses #_____: 10mg/kg IV every 2 weeks

MAINTENANCE DOSING (CAN ONLY BE SELECTED ONCE PATIENT HAS COMPLETED 18 MONTHS OF STANDARD DOSING AT THE 2 WEEK INTERVAL PER THE PI)
☐ Doses #_____: 10mg/kg IV every 4 weeks

REQUIRED CLINICAL DOCUMENTATION CHECKLIST:

_____ Demographics page with insurance info
_____ Progress note with cognitive testing within the last 6 months
_____ Patient's recent weight
_____ Amyloid PET scan or CSF results with amyloid confirmation
_____ MRI of the brain within the last year
_____ If Medicare patient, Alzheimer's Registry number (i.e. ALZH-00000)

Please indicate here any preferred variation from standard orders including longer infusion times, less doses, etc.: _____

• All patients will be kept for 30 minutes of monitoring following completion of the first infusion and then on a case-by-case basis subsequently for any clinical issues.

Additional Orders: By signing this order, you agree to the following orders unless otherwise noted.
• Hold infusion and notify provider if patient reports: Headache, dizziness, nausea, vision changes, new or worsening confusion, balance concerns, or change in mentation.
• Infusion/allergic reactions may be managed by clinical staff in real time per facility protocol. The prescriber's office will be notified in real time of any infusion reactions.

Provider Signature:_____ **Date:**_____

Notes/Additional Comments: _____