Leqembi® (lecanemab-irmb) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		
Address:				
Phone:	**Height:**	☐ Inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Details needed for therapy:

- Baseline brain MRI from within the past year. Subsequent brain MRI reports and written approval by the ordering prescriber must be obtained prior to the 5th, 7th, and 14th infusions.

Leqembi® (lecanemab-irmb) Prescription

Leqembi® (lecanemab-irmb) refill as directed x 1 year

Infuse 10mg/kg (_____mg) IV every 2 weeks

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.

Using a 50ml NS IV bag, flush IV tubing with NS 10 to 20 mL after each infusion.

Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Other: _____

IV Flush Orders

☐ Peripheral: NS 2-3 mL pre-/post-use

☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.

☐ Pulse ox monitoring during infusion. Call MD if O_2 sat is below_____

Refill above ancillary orders as directed x 1 year.

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

Prescriber Signature:_____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

