Leqembi® (lecanemab-irmb) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ Inches ☐ cm	Weight:	☐ lbs ☐ kg

Allergies: ☐ NKDA OR (List):

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 3rd, 5th, 7th, and 14th infusions.

Leqembi® (lecanemab-irmb) Prescription

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

Select One:

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

☐ Infuse 10mg/kg (_____mg) IV every 4 weeks *(after 18 months of therapy)*

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 of infusion related reactions 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) SUBQ 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. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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:**	

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING**: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

 © 2023 All rights reserved.