Leqembi (lecanemab-irmb)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:	Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:		Next Due Date:

DIAGNOSIS AND ICD 10 CODE	
☐ Alzheimer's disease with early onset	ICD 10 Code: G30.0
☐ Mild Cognitive Impairment, So stated	ICD 10 Code: G31.84
☐ other ICD10 Code:)	Description:

G30.X CODES BELOW REQUIRE SECONDARY F02.8x DIAGNOSIS CODE- PLEASE SELECT ONE FROM EACH COLUMN

	Secondary
☐ G30.1 Alzheimer's disease late onset	☐ F02.80 Dementia without behavioral disturbance
☐ G30.8 Other Alzheimer's disease	☐ F02.81 Dementia with behavioral disturbance
☐ G30.9 Alzheimer's disease , unspecified	

REQUIRED DOCUMENTATION

☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes

Prescriber must indicate that the following requirements have been met (*provide supporting documentation*)

☐ Beta Amyloid Pathology Confirmed via:

↳ ☐ Amyloid PET Scan **OR** ☐ CFS Analysis-Date: _____ Result: _____

☐ Cognitive Assessment Used: _____ Date: _____ Result: _____

☐ ApoE ε4 Genetic Test - Date: _____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier

MEDICARE REGISTRATION # IF APPLICABLE __ __ __ __ __ __ __ __ __

MEDICATION ORDERS(Note: Only one stage of treatment may be ordered at a time

☐ Stage 1 (Infusions #1-4)	☐ Stage 2 (Infusions #5 and #6)	☐ Stage 3 (Infusions #7-13)	* Stage 4 (Infusions #14 & beyond)
✓Leqembi 10mg/kg IV every two weeks x 4 doses. Each infusion to be given over one hour. **Required Documentation to Initiate this Phase:** ☐ MRI of brain within one year prior to first infusion. Date of MRI: o By checking this box, I confirm that Beta Amyloid Pathology has been confirmed via CSF or PET.	✓Leqembi 10mg/kg IV every two weeks x 2 doses. Each infusion to be given over one hour. **Required Documentation to Initiate this Phase:** ☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #5. I have reviewed the results and clear patient to proceed with infusions #5 and #6.	✓Leqembi 10mg/kg IV every two weeks x 7 doses. Each infusion to be given over one hour. **Required Documentation to Initiate this Phase:** ☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #7. I have reviewed the results and clear patient to proceed with infusions #7 through #13.	☐Leqembi 10mg/kg IV every **two weeks** over one hour. **OR** ☐ Leqembi 10mg/kg IV every **four weeks** over one h our. **Required Documentation to Initiate this Phase:** ☐ By checking this box, I confirm that patient has undergone MRI of brain before dose #14. I have reviwed the results and clear patient to proceed

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become 01/29/25part of the patient's medical record.

Created 01/29/25

PRE-INFUSION : ☑ Confirm baseline MRI results prior to initiation of treatment ☑ Confirm MRI completed and reviewed by prescriber prior to the 5th, 7th, and 14th treatment ☑ Measure and record weight prior to each treatment to determine dose ☑ Hold infusion and notify provider if patient reports: • Headache • Dizziness • Nausea • Vision Changes • New or worsening confusion	**Post -INFUSION** : ☑ Educate patient/care partner to report headache, dizziness, nausea, vision changes, or new/worsening confusion. ☑ Fax infusion record to provider below :

PRESCRIBER INFORMATION		
Provider Name (print)	Provider Signature**:	Date:
Office Phone	Office Fax	

***Amyloid Related Imaging Abnormalities (ARIA): Enhanced clinical vigilance for ARIA is recommended during the first 14 weeks of treatment with LEQEMBI. Referring physician to monitor patient*