

Lecanemab-irmb (Leqembi)

Provider Order Form rev. 9/5/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ ☐ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: ☐ M / ☐ F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

☐ G30.0 Alzheimer's disease w/ early onset ☐ G30.8 Other Alzheimer's disease ☐ G30.9 Alzheimer's disease unspecified
☐ G30.1 Alzheimer's disease w/ late onset ☐ Other: _____ Description: _____

REQUIRED INFORMATION FOR MEDICARE

☐ Z00.6: Encounter for examination for normal comparison and control in clinical research program

Medicare Trial Registry Number: _____

Date of Medicare Registry Submission: _____

THERAPY ADMINISTRATION & DOSING

☐ Administer Leqembi 10mg/kg x _____ kg = _____ mg IV every 2 weeks. Infuse in 250ml 0.9% NS over 1 hour

☐ Administer Leqembi 10mg/kg x _____ kg = _____ mg IV every 4 weeks. Infuse in 250ml 0.9% NS over 1 hour

(Patients must have completed 18 months of treatment before transitioning to monthly dosing)

☒ Flush the IV line with normal saline to make sure all medication is infused.

☒ Dosing Weight: _____ kg

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☒ Hold infusion and notify provider for:

- Hold if amyloid beta pathology has not been confirmed.
- Abnormal vital signs
- No brain MRI results in chart (need MRI within one year of starting treatment, and prior to 3rd, 5th, 7th, and 14th infusion).
- Signs of Amyloid Related Imaging Abnormalities (ARIA) as reported on MRI results.
- New or worsening headache or altered mental status.

☒ Record vital signs before infusion and prior to patient discharge

☒ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

☒ To report suspected adverse reactions, contact FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. Documentation confirming patient's enrollment in CMS National Patient Registry, MRI at initial and throughout treatment, PET or CSF analysis for amyloid bodies, cognitive function score

Provider Name (print) _____

Provider Signature _____

Date _____

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.