NATIONAL INFUSION CENTER ASSOCIATION

Patient Name:

DOB:

LECANEMAB-IRMB (LEQEMBI™) INFUSION ORDERS

Diagnosis:

(1)

- □ G30.0 Alzheimer's Disease, Early Onset
- □ G30.1 Alzheimer's Disease, Late Onset
- □ G30.8 Other Alzheimer's disease
- □ G30.9 Alzheimer's disease, unspecified
- □ G31.84 Mild Cognitive Impairment, So Stated

← G30.X codes require secondary F02.8X code →

- □ F02.80 Dementia without behavioral disturbance
- □ F02.81 Dementia with behavioral disturbance
- □ Other: _____ (ICD-10 Code) _____ (Description)

Gender: □ M □ F	**Height:** □ CM □ IN	**Weight:** □ KG □ LB

Prescriber must indicate the following requirements have been met (please provide documentation):

(2) ☐ Beta Amyloid Pathology Confirmed Via:

☐ Amyloid PET Scan Date: _____ OR ☐ CSF Analysis Date: _____ Result: _____

(3) ☐ Cognitive Assessment Used: _____ Date: _____ Result: _____

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

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.

Medication:

☑ Administer LEQEMBI 10 mg/kg intravenously over at least 60 minutes.

☑ Dilute required volume of lecanemab-irmb in 250 ml 0.9% sodium chloride and infuse using a terminal low-protein binding 0.2-micron in-line filter.

☑ If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

Treatment Frequency

☑ Schedule treatments every two weeks (at least 14 days apart).

Post-Infusion:

☑ Educate patient/care partner to report headache, dizziness, nausea, vision changes, or new/worsening confusion.

☑ Fax treatment notes to provider at number below:

Prescriber name (print): _____

Fax: _____

Prescriber signature: _____

Date: _____

INFO@INFUSIONCENTER.ORG
3307 NORTHLAND DR. STE 160 | AUSTIN, TX 78731
NATIONAL INFUSION CENTER ASSOCIATION

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