smartinfusion THERAPY SERVICES

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www.MySmartInfusion.com

Leqembi (lecanemab)
Infusion Order Form

Location
☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

Primary ICD 10 Code will be Z00.6 Encounter for examination for normal comparison and control in clinical research program.

☐ Alzheimer's Disease with Early Onset ICD 10 Code: G30.0
☐ Alzheimer's Disease with Late Onset ICD 10 Code: G30.1
☐ Other Alzheimer's Disease ICD 10 Code: G30.8
☐ Alzheimer's Disease Unspecified ICD 10 Code: G30.9

Required Labs (Attach results)

ApoE E4 status

Required Tests (attach results)

MRI's need to be performed at baseline & prior to the 3rd, 5th, 7th and 14th infusion

Notes: _____

_____

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 125mg IV

Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV

Other: _____ Route: _____

Dose: _____ Frequency: _____

Leqembi Medication Order

Refill x12 months unless otherwise noted:

Patient Weight: _____ KG

Dosage

☐ 10mg/kg IV every two weeks for infusions #1 - #23
☐ 10mg/kg IV every two weeks for infusions #24 - #36
☐ Maintenance dose: 10mg/kg every 4 weeks.

*Doses will be rounded to nearest 10mg

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Cognitive Assessment Score _____
☐ MRI of the Brain within 1 year
☐ Confirmed presence of amyloid pathology (Amyloid PET scan or +CSF)
☐ CMS National Patient Registry # _____
☐ Copy of Insurance Card (front/back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____