Lecanemab-irmb (Leqembi)

Provider Order Form rev. 7/29/2025

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: _____

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 competed 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

LABORATORY ORDERS

☐ Other: _____

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 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.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.