INFUSION CENTER OF NEW ENGLAND

Checklist for Leqembi (lecanemab) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____ **NPI:** _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Leqembi
  - Medication list and allergies
  - Cognitive assessment and functional assessment with score and interpretation
- ❑ Supporting lab reports/imaging for Leqembi treatment
  - MRI within 1 year of treatment start
  - Confirmation of amyloid beta pathology (LP or PET Scan)
  - Recommended: ApoE testing to determine ARIA risk
- ❑ Durable Power of Attorney for Health Care (DPAHC), if applicable
- ❑ Leqembi Prescribing Order (see attached)

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

LEQEMBI insurance coverage varies.

Patients starting on this medication should be aware that there is no guarantee of insurance coverage for medication costs or administration costs.

****Patients will be responsible for all costs not covered by insurance.****

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Leqembi (lecanemab)

Date of Order: _____ ❑ New Start ❑ Maintenance
Date of last infusion: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s):_____

❑ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV in 50ml over 15min
❑ Other: _____

Lab Orders:

❑ _____

LEQEMBI Medication Order:

❑ Leqembi 10mg/kg in 250ml 0.9% Sodium Chloride infused over 1 hour every 2 weeks

❑ Other: _____

Administration:

- ✓ Hold infusion if no MRI Brain prior to the 5th, 7th, and 14th infusion, then annually
- ✓ Hold infusion and notify provider if patient experiencing any of the following signs of ARIA:
  - Headache, Confusion, Dizziness, Nausea, Vision Changes
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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