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)
- ☐ Leqembi Indication Checklist (see attached)

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

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

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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LEQEMBI Indication Checklist

INFORMATION REQUIRED FOR TREATMENT INITIATION	
1) **Patient ICD-10** (select all that apply) ☐ G30.0 Alzheimer's disease with early onset ☐ G30.1 Alzheimer's disease with late onset ☐ G30.9 Alzheimer's disease, unspecified ☐ G31.84 Mild cognitive impairment	**Clinical Diagnosis** (select one) ☐ Mild cognitive impairment due to AD ☐ Mild AD Dementia

2) **Cognitive Screening: within 6 months** **Date:** _____

Name of Test Used: _____ Score: _____

Interpretation: _____

Functional Screening: within 6 months **Date:** _____

Name of Test Used**:** _____ Score: _____

Interpretation: _____

3) **Confirmation of Amyloid-Beta Pathology:** MUST provide supporting documentation

☐ Amyloid PET Scan Date: _____ Result: _____

☐ CSF Amyloid Confirmation Date: _____ Result: _____

Notes:

4) **Monitoring for Amyloid Related Imaging Abnormalities (ARIA)**

LEQEMBI requires brain MRI within 1 year of treatment start date

☐ Initial MRI Brain Date: _____

Result:

Evidence of ARIA-E ☐ Negative ☐ Positive

Evidence of ARIA-H ☐ Negative ☐ Positive

5) **Schedule for MRI Monitoring:** the following is required by Infusion Center of New England

☐ Obtain MRI prior to the 5th, 7th, and 14th infusion, then annually

Notes:

6) **Is the patient on anticoagulation?** ☐ Yes ☐ No

7) **Is the patient on antiplatelets?** ☐ Yes ☐ No

8) **Has ApoE testing been performed?** ☐ Yes ☐ No Result:

9) **CMS REGISTRATION NUMBER (REQUIRED)** _____ **Date:** _____

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