SPECIALTY INFUSION CENTER
An Access Infusion Care Company

LECANEMAB ORDERS (Leqembi)

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ ApoE εe4 Genetic test
☐ Amyloid beta pathology by PET scan, CSF/Plasma sample, Brain MRI with negative ARIA result
☐ Medicare registry number if applicable
☐ Ensure patient has arrangements for MRIs at the appropriate intervals for treatment
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

LECANEMAB ORDERS (Leqembi)

CENTERS AT SIC
An Access Infusion Care Managed Company

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐PIV ☐PICC ☐Port ☐Other

DIAGNOSIS
☒ Dx Code/description: Z00.6 Encounter for examination for normal comparison and control in clinical research program.
☐Secondary Dx Code/description:
☐Other Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance info ☐ H&P, labs, tests, progress notes supporting dx	
☐ApoE εe4 Genetic test-Date: Result: ☐Homozygote ☐Heterozygote ☐Noncarrier	
☐Amyloid beta pathology by PET scan, CSF/Plasma sample	☐Brain MRI with negative ARIA result-Date:
☐Medicare Beneficiaries- NCT Registry #:	
Brain MRI results and written approval from referring provider must be obtained prior to 3rd, 5th, 7th, and 14th infusion	

PRESCRIBING INFORMATION

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen:☐650mgPO ☐1000mgPO	Methylprednisolone:☐100mgIV ☐125mgIV ☐ mgIV
Diphenhydramine:☐25mgPO ☐50mgPO ☐25mgIV ☐50mgIV	Other:☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒**Lecanemab (Leqembi)**	100mg/mL	☐**Months 0-12: 10mg/kg**-infuse in 250ml 0.9%NS IV over 60 minutes every 2 weeks (hold infusion #3, #5, and #7 for MRI results) ☐**Months 13-18: 10mg/kg**-infuse in 250ml 0.9%NS IV over 60 minutes every 2 weeks (hold infusion #14 for MRI results) ☐**Months 19+: 10mg/kg**-infuse in 250ml 0.9%NS IV over 60 minutes every 4 weeks	☒#sufficient for weight-based dose Refills:

Use current documented weight; round calculated dose to nearest vial size +/- 10% of dose.
If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for 30 minutes after the 1st infusion, no observation for subsequent infusions if no IRRs

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

©Specialty Infusion Center

Print, complete, and fax completed form to (855) 857-3834

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834