

LEQEMBI® (lecanemab-irmb)



Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- | | | |
|--|---|---|
| <input type="checkbox"/> Patient Demographics and Insurance Card | <input type="checkbox"/> Medication List | <input type="checkbox"/> Functional & Cognitive Assessment |
| <input type="checkbox"/> Clinical/Progress Notes Supporting Dx | <input type="checkbox"/> MRI within the past year | <input type="checkbox"/> PET scan or CSF results with amyloid beta confirmation |
| <input type="checkbox"/> Medicare Registry # _____ | <input type="checkbox"/> Recent lab results | |


Diagnosis

-  ICD-10 Code (required): _____
- | | |
|---|---|
| <input type="checkbox"/> Alzheimer's disease with early onset | <input type="checkbox"/> Alzheimer's disease, unspecified |
| <input type="checkbox"/> Alzheimer's disease with late onset | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Encounter for examination for normal comparison and control in clinical research program  REQUIRED AS PRIMARY DX | |

Pre-Medication

- | | |
|--|---|
| <input type="checkbox"/> Per violet health protocol: No recommended standard pre-medications for Tocilizumab | <input type="checkbox"/> Acetaminophen (Tylenol) PO <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg |
| | <input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV |
| | <input type="checkbox"/> Methylprednisolone (Solu-Medrol) IV <input type="checkbox"/> 40mg <input type="checkbox"/> 125mg |
| | <input type="checkbox"/> Cetirizine (Zyrtec) 10 mg PO |
| <input type="checkbox"/> Other: _____ | |

Therapy Administration

- | | |
|--|---|
| <input type="checkbox"/> Leqembi 10mg/kg IV in 250 mL of 0.9% Sodium Chloride every two weeks | <input type="checkbox"/> RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) |
| Refills: | <input type="checkbox"/> RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines. |
| <input type="checkbox"/> x 1 year <input type="checkbox"/> Other: _____ | <input type="checkbox"/> RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration. |
|  Order valid for one year unless otherwise stated | <input type="checkbox"/> Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box |

Lab Orders

- | | |
|---|---|
| <input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ | <input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ |
| <input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ | <input type="checkbox"/> Other: _____ |

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____