Leqembi® (lecanemab-irmb)

PRESCRIBER ORDER FORM

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

Clinical Information

Primary Diagnosis Description:		ICD-10 Code:	

Details needed for therapy:
Baseline brain MRI from within the past year. Subsequent brain MRI reports and written approval by the ordering prescriber must beobtained prior to the 5th, 7th, and 14th infusions.

Leqembi® (lecanemab-irmb) Prescription

Leqembi® (lecanemab-irmb) refill as directed x 1 year

Select One:

☐ Infuse 10mg/kg (_____mg) IV every 2 weeks

☐ Infuse 10mg/kg (_____mg) IV every 4 weeks (after 18 months of therapy)

Medication shall be added to a 250ml 0.9% NaCl infusion bag and infused over 1 hour. The IV line shall have a 0.2 micron in-line filter attached.

Using a 50ml NS IV bag, flush IV tubing with NS 10 to 20 mL after each infusion.

Check vitals and monitor for signs and symptoms of infusion related reactions at start, throughout infusion, and after completion

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like DeliverIt Infusion & Specialty to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (< 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Other: _____

IV Flush Orders

☐ Peripheral: NS 2-3 mL pre-/post-use

☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

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Ancillary Orders

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.

☐ Pulse ox monitoring during infusion. Call MD if O2 sat is below _____

Refill above ancillary orders as directed x 1 year. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Date

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance