Ascension Rx

Lecanemab-irmb (Leqembi & Biosimilars) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

☐ Labs to be reviewed or ordered by infusion center

- ☐ Baseline
  - ☐
- ☐ Maintenance (every _____)
  - ☐

☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)

☐ Other: _____ ☐

Provider Information

Obtain a recent baseline brain MRI prior to initiating treatment and prior to the 3rd, 5th, 7th, and 14th infusions.

Amyloid related imaging abnormalities (ARIA): Enhanced clinical vigilance for ARIA is recommended during the treatment with Lecanemab. Testing for ApoE ε4 status should be performed prior to initiation of treatment to inform the risk of developing ARIA.

Live vaccines should not be given concurrently.

MEDICARE Patients Only: CMS Registry Enrollment

- ☐ Medicare Beneficiary ID (MBI):_____
- ☐ CED Study Identification (NCT): _____
- ☐ CED Study Identification (ALZH): _____

Nursing Order

☑ Verify MRI is done prior to initiating treatment and 3rd, 5th, 7th, and 14th infusions. Notify the provider if not done prior to infusion.

☑ Verify patient is not experiencing symptoms of Amyloid related imaging abnormalities (ARIA) such as headache, dizziness, nausea, confusion, vision changes, seizures, and difficulty walking prior to infusion.

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- [x] Do not administer lecanemab with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- [x] Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

☐ Acetaminophen 650 mg PO once	☐ Dexamethasone 20 mg IV once
☐ Loratadine 10 mg PO	☐ Dexamethasone 20 mg PO once
☐ Cetirizine 10 mg PO	☐ Methylprednisolone 125 mg IV once
☐ Famotidine 20 mg IV once	☐ Methylprednisolone 40 mg IV once
☐ Famotidine 20 mg PO once	☐ Other: _____

IV Site Orders

- [x] Follow standard protocol for IV site management
- [x] In absence of standard protocol, follow the orders below:
  - [x] Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
  - [x] Start peripheral IV or access central line for infusion
  - [x] Sodium chloride 0.9% 10 mL flush to IV site as needed
  - [x] Heparin 50 units/5 mL flush to IV site as needed (central line only)
  - [x] Heparin 500 units/5 mL flush to IV site as needed (central line only)
  - [x] May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

Medication Orders

☐ Lecanemab 10 mg/kg (_____ mg) IV over 1 hour once every 2 weeks

<u>May use this regimen after 18 months of therapy:</u>

☐ Lecanemab 10 mg/kg (_____ mg) IV over 1 hour once every 4 weeks

☐ Lecanemab 10 mg/kg (_____ mg) IV over 1 hour once every ____ weeks

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

☐ Payer-mandated substitution
☐ Financial stewardship
☐ Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

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Administration Instructions

Infuse through a low protien 0.2 micron inline filter.

Monitor patients for 30 minutes after the first infusion.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated