



BAMF Health Theranostics Center • Molecular Therapy Clinic
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LEQEMBI Order
 Revision 09-24-2024

Please Fax completed order to BAMF Health at Fax # 616-253-8365

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

Allergies: _____ Weight (kg): _____ Height (cm): _____

ICD-10 Code(s) & Description:

NOTE: Please send all relevant demographic and insurance information

The patient has an existing prior authorization: Yes (please fax copy to BAMF Health) NO

REFERRING OFFICE

Contact Name: _____ Contact Phone #: _____

Ordering Provider: _____ Provider NPI: _____

Practice Name: _____ Phone #: _____ Fax #: _____

DIAGNOSIS

Mild cognitive impairment, so stated (ICD-10 code: G31.84)

Alzheimer's Disease with Early Onset (ICD-10 code: G30.0)

Other: _____

(ICD-10 Code: _____)

Alzheimer's Disease with Late Onset (ICD-10 code: G30.1)

Mild dementia due to Alzheimer's Disease (ICD-10 code: G30.9)

CLINICAL HISTORY – REQUIRED INFORMATION

- Current Medication list
- Recent provider note(s)
- PET scan or CSF results with amyloid beta confirmation
- Recent MRI of brain (within past year)
- Results of cognitive assessment with score: _____ (MMSE 22-30, CDR-GS 0.5 or 1)

- Confirmation of functional impairment w/ validated tool:
 - FAQ Score FAST CDR-SB
- For Medicare / Medicare Advantage, please include a copy of the CMS Registry enrollment that includes submission number
- APOE ε4 test results (if applicable)

PRE-MEDS FOR 1ST and 2ND DOSE ONLY

Acetaminophen (Tylenol®) 500 mg PO prior to infusion

Decadron 10 mg IVP over 10 minutes prior to infusion

PRE MEDS FOR SUBSEQUENT DOSES

Acetaminophen (Tylenol®) 500 mg PO prior to infusion

Please instruct patient to take acetaminophen 650 mg every 6 hours routinely for the next 24 hours while at home.

NURSING ORDERS

Vitals prior to infusion If SBP ≥ 150 mmHg, hold treatment and call provider.

Vitals q15 min x1, end of infusion and prior to discharge

Patients to be monitored for 1 hr following their first and second infusion

Call prescriber and/or 911 for any hypersensitivity reactions including but not limited to fever, flu-like symptoms, nausea, vomiting, hypertension, and oxygen desaturation

THERAPY ADMINISTRATION

Drug: LEQEMBI (lecanemab-irmb) Dose: 10mg/kg Route: IV over 60 minutes

Frequency: Every 2 Weeks Refill: 6 months 1 year Other: _____

Date of last infusion if not at BAMF Health: _____ RX Expiration Date: _____

Rule Out: Amyloid related imaging abnormalities (Brain Edema or Hemorrhage)
 Other: _____

Order: MR Brain w/o contrast (prior to 5th Lecanemab infusion)
 MR Brain w/o contrast (prior to 7th Lecanemab infusion)
 MR Brain w/o contrast (prior to 14th Lecanemab infusion)

Additional Orders: By signing this order you agree to the following orders, unless otherwise noted.

- Hold infusion and notify provider if patient reports: Headache, Dizziness, Nausea, Vision Changes, New or Worsening Confusion.
- May initiate IV catheter patency protocol
- Infusion/allergic reactions may be managed per facility protocol.

Provider Signature: _____ Date: _____