BIG SKY IV CARE
An Access Infusion Care Company

LEQEMBI (LECANEMAB-IRMB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD-10 CODE

☐ G30.0 Alzheimer's disease with early onset
☐ G31.84 Mild Cognitive Impairment due to Alzheimer's Disease
☐ G30.1 Alzheimer's disease late onset
☐ G30.8 Other Alzheimer's disease
☐ G30.9 Alzheimer's disease, unspecified

SECONDARY DIAGNOSIS CODE

☐ F02.80 Dementia without behavioral disturbance
☐ F02.81 Dementia with behavioral disturbance
☐ Z00.6 Encounter for examination for normal comparison and control in clinical research program

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ H&P and Clinical/Progress notes supporting primary diagnsosis
☐ Beta Amyloid Pathology Confirmed via: _____
☐ Amyloid PET Scan **OR** ☐ CFS Analysis - Date: _____ Result: _____
☐ Cognitive Assessment Used: _____ Date: _____ Result: _____
☐ ApoE ε4 Genetic Test - Date: _____ Result: ☐ Homozygote ☐ Heterozygote ☐ Noncarrier

☐ Patient demographics AND insurance information
☐ **MEDICARE REGISTRATION # (if applicable)** _____

MEDICATION ORDERS

Leqembi 10mg/kg IV over one hour

Frequency (Only one stage of treatment may be ordered at a time)	MRI Requirements	Results (must be cleared by ordering provider)
☐ Stage 1 (Infusions 1-4): every two weeks x 4 doses	MRI within one year prior to initial infusion	MRI Date: _____ Cleared : Yes ◯ or No ◯
☐ Stage 2 (Infusions 5-6): every two weeks x 2 doses	MRI prior to dose #5	MRI Date: _____ Cleared : Yes ◯ or No ◯
☐ Stage 3 (Infusions 7-13): every two weeks x 7 doses	MRI prior to dose #7	MRI Date: _____ Cleared : Yes ◯ or No ◯
☐ Stage 4 (Infusions 14 and beyond): every two weeks x _____ doses	MRI prior to dose #14	MRI Date: _____ Cleared : Yes ◯ or No ◯
☐ >18 months of treatment: every _____ weeks x _____ doses	MRI frequency per provider	MRI Date: _____ Cleared : Yes ◯ or No ◯

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
☐ RN to flush and lock VAD/CVAD per company protocol
Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO prior to infusion
☐ Other: _____
☐ Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):
Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)
Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
Fax: (855) 857-3834

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