**ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN**

**Allergies/Reactions:**

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

**ORDERS WITH CHECK BOXES** When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

## Lecanemab-irmb (Leqembi®):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: ( _____ ) _____ - _____ ❑ May leave message

**Diagnosis:** ❑ Alzheimer Disease **ICD -10 Code:** ❑_____

**Required:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
***If required documentation not received with order, scheduling of treatment will be delayed until complete information is available***

**Baseline Labs Required:**

- None

**MD Communication:**

PET or lumbar puncture to confirm presence of amyloid beta pathology (prior to initiation); brain MRI (prior to initation [within 1 year]; prior to 5th, 7thm 14th infusions; monitor closely for clinical or MRI changes.

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintainance, and Discontinuation of Central VenousCatheters-Flushing, Dressing Changes and Removal.

☑ **Treatment Regimen:**
Patient weight _____(kg)
❑ Lecanemab-irmb (Leqembi) 10 mg/kg = _____ mg IV infusion over 60 minutes every 2 weeks.

☑ **Vital signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

**If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)**

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

**Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.**

**Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)**

| Provider Signature | Print Name | Date | Time |
|---|---|---|---|
| | | | |

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

**Patient Identification - Always Attach Patient Label**

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

# ALZHEIMER DISEASE

MultiCare

60-0367-9 (11/24))