

# McLeod Health

## Lecanemab-irmb (Leqembi) Treatment Plan

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Allergies: \_\_\_\_\_

Patient Primary Phone Number: \_\_\_\_\_

### Diagnosis (select one):

- ☐ G30.0 Alzheimer's disease with early onset ☐ G30.1 Alzheimer's disease with late onset
- ☐ G30.8 Other Alzheimer's disease ☐ G31.84 MCI of uncertain etiology
- ☐ Other: ICD 10 Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

### Pre-Medications: \*\*administered 30 minutes prior to infusion\*\*

- ☐ None
- ☐ Acetaminophen 650 mg PO
- ☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP
- ☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 mg Route: IVP
- ☐ Famotidine: Dose: 20 mg Route: ☐ PO or ☐ IVPB
- ☐ Other (include drug, dose, and route): \_\_\_\_\_

### Drug Orders:

- Lecanemab (Leqembi) (J0174) 10 mg/kg per 250 mL Sodium Chloride 0.9% IV to infuse over 60 minutes once every 2 weeks
- Order Duration: One year unless otherwise specified (Other: \_\_\_\_\_)

### Standing Orders:

- Monitor patient for 30 minutes following completion of infusion.
- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Pre-Screening Requirements:

- Baseline MRI required prior to treatment initiation; **physician responsible for follow up imaging per package insert. Must report follow up imaging results to infusion services team.**
- Amyloid beta pathology status and Apolipoprotein E e4 status confirmed prior to treatment initiation

**Previous Therapies:**

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received lecanemab at another facility, please provide last date received: \_\_\_\_\_
- If patient has previously received another biologic therapy, please provide the name: \_\_\_\_\_ and the last date received: \_\_\_\_\_

**Insurance Information:**

Insurance Plan Name: \_\_\_\_\_

Insurance Identification Number: \_\_\_\_\_

Insurance Customer Service Contact Number: \_\_\_\_\_

**Preferred Treatment Location**

- ☐ McLeod Regional Medical Center (Florence)   ☐ McLeod Health Loris   ☐ McLeod Health Cheraw  
☐ McLeod Health Seacoast (Little River)   ☐ McLeod Health Dillon   ☐ McLeod Health Clarendon (Manning)

**Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at [medicationaccessteam@mcleodhealth.org](mailto:medicationaccessteam@mcleodhealth.org).**