



Oregon Health & Science University  
Hospital and Clinics Provider's Orders

PO9031



ADULT AMBULATORY INFUSION ORDER

**Lecanemab (LEQEMBI)**

Infusion

Page 1 of 2

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

*Patient Identification*

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE.**

Weight: \_\_\_\_\_ kg      Height: \_\_\_\_\_ cm

Allergies: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_ Patient to follow up with provider on date: \_\_\_\_\_

**\*\*This plan will expire after 365 days at which time a new order will need to be placed\*\***

**GUIDELINES FOR ORDERING**

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Confirm the presence of amyloid beta pathology prior to initiating treatment.
3. Obtain a recent (within one year) brain MRI prior to initiating treatment to evaluate for pre-existing Amyloid Related Imaging Abnormalities (ARIA).
4. Obtain an MRI prior to the 3rd, 5th, 7th, and 14th infusions. If radiographically observed ARIA occurs, treatment recommendations are based on type, severity, and presence of symptoms.
5. Enhanced clinical vigilance for ARIA is recommended during the first 14 weeks of treatment with LEQEMBI. If patient experiences symptoms suggestive of ARIA, clinical evaluation should be performed, including MRI if indicated. If ARIA is observed on MRI, careful clinical evaluation should be performed prior to continuing treatment.

**NURSING ORDERS:**

1. Monitor for infusion reactions during infusion and observe for at least 1 hour after completion of first two infusions. The highest incidence of infusion reactions occurs with the first infusion.
2. Confirm an MRI was performed prior to the 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, and 14<sup>th</sup> infusions.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes.

**PRE-MEDICATIONS:** (Administer 30 minutes prior to infusion)

**Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)**

1. Acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION, every visit
2. DiphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION every visit.  
**Give either diphenhydrAMINE or loratadine, not both.**
3. Loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION and diphenhydrAMINE is not given, every visit.  
**Give either loratadine or diphenhydrAMINE, not both.**
4. Dexamethasone (DECADRON), 10 mg, intravenous, ONCE AS NEEDED IF PATIENT HAD PRIOR INFUSION REACTION, every visit.



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**MEDICATIONS:**

- Lecanemab (LEQEMBI), 10 mg/kg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1 hour, every 2 weeks.

**HYPERSENSITIVITY MEDICATIONS:**

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydramine (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

**By signing below, I represent the following:**

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in:  Oregon  \_\_\_\_\_ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

**My physician license Number is # \_\_\_\_\_ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION);** and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

<b>Provider signature:</b> _____	<b>Date/Time:</b> _____
<b>Printed Name:</b> _____	<b>Phone:</b> _____ <b>Fax:</b> _____

**Please indicate the patient's preferred clinic location below**

<input type="checkbox"/> <b>HILLSBORO MEDICAL CENTER</b> 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
<input type="checkbox"/> <b>ADVENTIST HEALTH – PORTLAND</b> Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
<input type="checkbox"/> <b>ADVENTIST HEALTH – COLUMBIA GORGE</b> Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058	Phone (541) 296-7585 Fax (541) 296-7610