NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Leqembi (Lecanemab) Order Form – J0174

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

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

- **Prior to initiation of therapy:**
  - **Documentation of brain MRI (within one year) is required.**
  - **Apolipoprotein E ε4 (ApoE ε4) status testing**

- **Brain MRIs are also required prior to doses 5, 7, and 14.**

Leqembi Dosing:

- **10mg/kg IV every 2 weeks**

Orders valid through ____/____/

Leqembi administration:

- Administer over 60 minutes through an IV line containing a 0.22 micron, in-line filter.

***In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____