MIDLAND HEALTH

Lecanemab-irmb (LEQEMBI TM) Infusion Therapy Triage Questions for Infusion RN

Appointment Date:_____

Have you seen any other provider in the last two weeks who may have added or changed the dose of any medications, specifically anti-coagulants or anti-thrombotics?	*Yes* **STOP** *Call Provider*	*No*	*Plan: Delay? How Long?* *Infusion Rescheduled for (date):* *Other:*
Have you been to the ER or had any surgical procedures in the last two weeks where an anti-coagulant could have been administered?	*Yes* **STOP** *Call Provider*	*No*	*Plan: Delay? How Long?* *Infusion Rescheduled for (date):* *Other:*
In the last two weeks have you had any viral or flu like systems or any bacterial infection?	*Yes*	*No*	*Symptoms?* *Need to differentiate symptoms from viruses and bacteria to infusion related reactions that can present as flu like symptoms.*
Have you had any vaccines in the last seven days?	*Yes* **STOP** *Call Provider*	*No*	*Delay infusion for seven days post vaccine to avoid misrepresentation of side effects from vaccine and linking it to infusion related reactions.* *Infusion Rescheduled for (date):*
******MRI STUDIES – Do not administer the 5th, 7th, or 14th infusion until additional MRIs have been completed.** *******You must call ordering provider and receive approval to proceed before 5th, 7th, or 14th infusion has been injected.**			
MRI without Contrast – Prior to Infusion 5 *MRI Completed?*	*Yes* *Yes*	*No* *No* **STOP** *Call Provider*	*Did you speak with the Provider for approval of this dose? If no, call provider.* *Date of MRI Completed:* *MRI scheduled for (date):* *Infusion Rescheduled for (date):*
MRI without Contrast – Prior to Infusion 7 *MRI Completed?*	*Yes* *Yes*	*No* *No* **STOP** *Call Provider*	*Did you speak with the Provider for approval for approval of this dose? If no, call provider* *Date of MRI Completed:* *MRI scheduled for (date):* *Infusion Rescheduled for (date):*
MRI without Contrast – Prior to Infusion 14 *MRI Completed?*	*Yes* *Yes*	*No* *No* **STOP** *Call Provider*	*Did you speak with the Provider for approval of this dose? If no, call provider* *Date of MRI Completed:* *MRI scheduled for (date):* *Infusion Rescheduled for (date):*