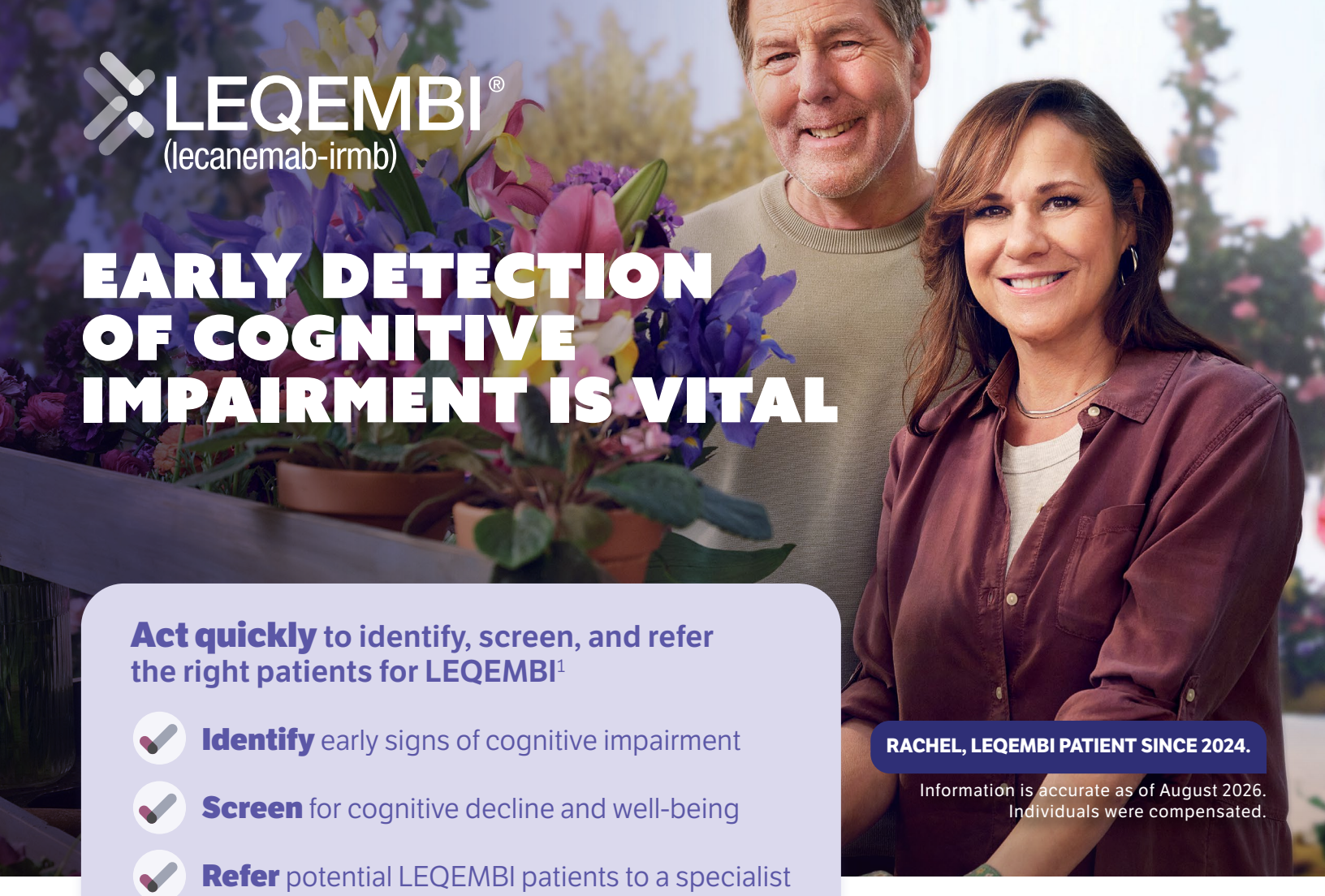


LEQEMBI®
(lecanemab-irmb)

EARLY DETECTION OF COGNITIVE IMPAIRMENT IS VITAL

Act quickly to identify, screen, and refer the right patients for LEQEMBI[1]

- **Identify** early signs of cognitive impairment
- **Screen** for cognitive decline and well-being
- **Refer** potential LEQEMBI patients to a specialist

RACHEL, LEQEMBI PATIENT SINCE 2024.

Information is accurate as of August 2026.
Individuals were compensated.

INDICATION

LEQEMBI® is indicated for the treatment of Alzheimer's disease (AD). Treatment with LEQEMBI should be initiated in patients with mild cognitive impairment (MCI) or mild dementia stage of disease, the population in which treatment was initiated in clinical trials.

SELECT SAFETY INFORMATION

WARNING: AMYLOID-RELATED IMAGING ABNORMALITIES (ARIA)

- **Monoclonal antibodies directed against aggregated forms of beta amyloid, including LEQEMBI, can cause ARIA, characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin deposition (ARIA-H). Incidence and timing of ARIA vary among treatments. ARIA usually occurs early in treatment and is usually asymptomatic, although serious and life-threatening events, including seizure and status epilepticus, can occur. ARIA can be fatal. Serious intracerebral hemorrhages (ICH) >1 cm, some of which have been fatal, have been observed with this class of medications. Because ARIA-E can cause focal neurologic deficits that can mimic an ischemic stroke, consider whether such symptoms could be due to ARIA-E before giving thrombolytic therapy to a patient being treated with LEQEMBI.**
  - **Apolipoprotein E ε4 (ApoE ε4) Homozygotes: Patients who are ApoE ε4 homozygotes (~15% of patients with AD) treated with this class of medications have a higher incidence of ARIA, including symptomatic, serious, and severe radiographic ARIA, compared to heterozygotes and noncarriers. Testing for ApoE ε4 status should be performed prior to initiation of treatment to inform the risk of developing ARIA. Prior to testing, prescribers should discuss with patients the risk of ARIA across genotypes and the implications of genetic testing results. Prescribers should inform patients that if genotype testing is not performed, they can still be treated with LEQEMBI; however, it cannot be determined if they are ApoE ε4 homozygotes and at higher risk for ARIA.**
- **Consider the benefit of LEQEMBI for the treatment of AD and the potential risk of serious ARIA events when deciding to initiate treatment with LEQEMBI.**

Please see additional Select Safety Information throughout.
Please see full Prescribing Information for LEQEMBI, including Boxed WARNING.

Recognize early signs of cognitive decline and refer patients to a specialist

Quickly discern which patients are appropriate to refer to a specialist for evaluation and potential early detection of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild AD dementia.[1]

1) **Identify** early signs of cognitive impairment

- ☐ **Note if the patient is experiencing a change in their cognitive baseline, including but not limited to the following symptoms of MCI**[1]:
  - Frequent forgetfulness
  - Poor judgment
  - Impaired decision-making
- ☐ **Inquire about the patient's family history of AD**[1]

2) **Screen** for cognitive decline and well-being

- ☐ **Use a validated tool–such as MoCA, Mini-Cog©, AD8, or SLUMS–to measure mild cognitive impairment**[2-5]
- ☐ **Consider common contributors to cognitive changes such as lack of sleep, mood, medications, and lifestyle**[1]
- ☐ **Order a comprehensive panel of tests that will help rule out potential causes of cognitive change or help a specialist identify MCI due to AD:**

Lab tests[6,7]**:**

Order routine labs to help rule out reversible causes of cognitive changes and support further diagnostic planning. Recommended tests include:

- Complete blood count (CBC)
- Comprehensive metabolic panel (CMP)
- Thyroid-stimulating hormone (TSH)
- Vitamin B_{12}

Neuroimaging[6,8]**:**

Rule out tumors, evidence of small or large strokes, damage from severe head trauma, or fluid buildup in the brain with imaging.

- ☐ MRI (contrast)
- ☐ CT scan (contrast)

Consider incorporating a blood-based biomarker (BBM) test as part of routine labs to evaluate patients with cognitive changes to determine the likelihood of Alzheimer's pathology and whether further testing is warranted*[9]

Learn more about BBMs on the CEOi Alzheimer's blood test performance database

*BBM tests are not intended as standalone diagnostic tests and should be integrated with patient history and other appropriate testing.[6,9]

AD8, Eight-item Informant Interview to Differentiate Aging and Dementia; CEOi, Global CEO Initiative on Alzheimer's Disease; CT, computed tomography; MoCA, Montreal Cognitive Assessment; MRI, magnetic resonance imaging; SLUMS, Saint Louis University Mental Status Examination.

3) **Refer** potential LEQEMBI® patients to a specialist

- ☐ **Based on results and evidence from the workup, consider helping your patients find a specialist**
- ☐ **Additional considerations for potential patients:**
  - Are they concerned about recent changes in their memory?
  - Are they accompanied by a family member or friend who shares their concerns?
  - Are they motivated to take on treatment?

Connect with an independent specialist

Please see additional Select Safety Information throughout.
Please see full Prescribing Information for LEQEMBI, including Boxed WARNING.

LEQEMBI® (lecanemab-irmb)

SELECT SAFETY INFORMATION

CONTRAINDICATION

Contraindicated in patients with serious hypersensitivity to lecanemab-irmb or to any of the excipients. Reactions have included angioedema and anaphylaxis.

WARNINGS AND PRECAUTIONS

AMYLOID-RELATED IMAGING ABNORMALITIES

Medications in this class, including LEQEMBI, can cause ARIA-E, which can be observed on MRI as brain edema or sulcal effusions, and ARIA-H, which includes microhemorrhage and superficial siderosis. ARIA can occur spontaneously in patients with AD, particularly in patients with MRI findings suggestive of cerebral amyloid angiopathy (CAA), such as pretreatment microhemorrhage or superficial siderosis. ARIA-H generally occurs with ARIA-E. Reported ARIA symptoms may include headache, confusion, visual changes, dizziness, nausea, and gait difficulty. Focal neurologic deficits may also occur. Symptoms usually resolve over time.

Incidence of ARIA

Symptomatic ARIA occurred in 3% and serious ARIA symptoms in 0.7% with LEQEMBI. Clinical ARIA symptoms resolved in 79% of patients during the period of observation. ARIA, including asymptomatic radiographic events, was observed: LEQEMBI, 21%; placebo, 9%. ARIA-E was observed: LEQEMBI, 13%; placebo, 2%. ARIA-H was observed: LEQEMBI, 17%; placebo, 9%. No increase in isolated ARIA-H was observed for LEQEMBI vs placebo.

Incidence of ICH

ICH >1 cm in diameter was reported in 0.7% with LEQEMBI vs 0.1% with placebo. Fatal events of ICH in patients taking LEQEMBI have been observed.

Risk Factors of ARIA and ICH

ApoE ε4 Carrier Status

Of the patients taking LEQEMBI, 16% were ApoE ε4 homozygotes, 53% were heterozygotes, and 31% were noncarriers. With LEQEMBI, ARIA was higher in ApoE ε4 homozygotes (LEQEMBI: 45%; placebo: 22%) than in heterozygotes (LEQEMBI: 19%; placebo: 9%) and noncarriers (LEQEMBI: 13%; placebo: 4%). Symptomatic ARIA-E occurred in 9% of ApoE ε4 homozygotes vs 2% of heterozygotes and 1% of noncarriers. Serious ARIA events occurred in 3% of ApoE ε4 homozygotes and in ~1% of heterozygotes and noncarriers. The recommendations on management of ARIA do not differ between ApoE ε4 carriers and noncarriers.

Radiographic Findings of CAA

Neuroimaging findings that may indicate CAA include evidence of prior ICH, cerebral microhemorrhage, and cortical superficial siderosis. CAA has an increased risk for ICH. The presence of an ApoE ε4 allele is also associated with CAA.

The baseline presence of at least 2 microhemorrhages or the presence of at least 1 area of superficial siderosis on MRI, which may be suggestive of CAA, have been identified as risk factors for ARIA. Patients were excluded from Clarity AD for the presence of >4 microhemorrhages and additional findings suggestive of CAA (prior cerebral hemorrhage >1 cm in greatest diameter, superficial siderosis, vasogenic edema) or other lesions (aneurysm, vascular malformation) that could potentially increase the risk of ICH.

Concomitant Antithrombotic or Thrombolytic Medication

In Clarity AD, baseline use of antithrombotic medication (aspirin, other antiplatelets, or anticoagulants) was allowed if the patient was on a stable dose. Most exposures were to aspirin. Antithrombotic medications did not increase the risk of ARIA with LEQEMBI. The incidence of ICH: 0.9% in patients taking LEQEMBI with a concomitant antithrombotic medication vs 0.6% with no antithrombotic and 2.5% in patients taking LEQEMBI with an anticoagulant alone or with antiplatelet medication such as aspirin vs none in patients receiving placebo.

Fatal cerebral hemorrhage has occurred in 1 patient taking an anti-amyloid monoclonal antibody in the setting of focal neurologic symptoms of ARIA and the use of a thrombolytic agent.

Additional caution should be exercised when considering the administration of antithrombotics or a thrombolytic agent (e.g., tissue plasminogen activator) to a patient already being treated with LEQEMBI. Because ARIA-E can cause focal neurologic deficits that can mimic an ischemic stroke, treating clinicians should consider whether such symptoms could be due to ARIA-E before giving thrombolytic therapy in a patient being treated with LEQEMBI.

Caution should be exercised when considering the use of LEQEMBI in patients with factors that indicate an increased risk for ICH and, in particular, patients who need to be on anticoagulant therapy or patients with findings on MRI that are suggestive of CAA.

Radiographic Severity With LEQEMBI

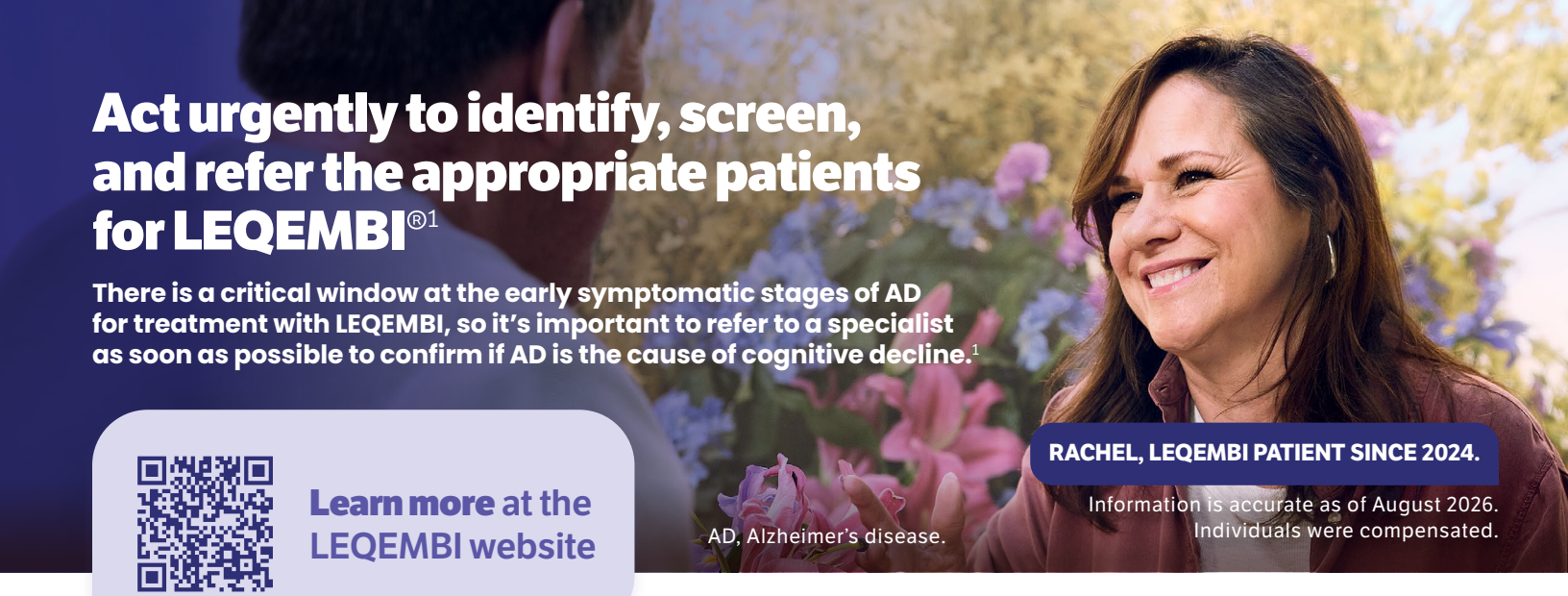
Most ARIA-E radiographic events occurred within the first 7 doses, although ARIA can occur at any time, and patients can have >1 episode. Maximum radiographic severity of ARIA-E with LEQEMBI was mild in 4%, moderate in 7%, and severe in 1% of patients. Resolution on MRI occurred in 52% of ARIA-E patients by 12 weeks, 81% by 17 weeks, and 100% overall after detection. Maximum radiographic severity of ARIA-H microhemorrhage with LEQEMBI was mild in 9%, moderate in 2%, and severe in 3% of patients; superficial siderosis was mild in 4%, moderate in 1%, and severe in 0.4% of patients. With LEQEMBI, the rate of severe radiographic ARIA-E was highest in ApoE ε4 homozygotes (5%) vs heterozygotes (0.4%) or noncarriers (0%). With LEQEMBI, the rate of severe radiographic ARIA-H was highest in ApoE ε4 homozygotes (13.5%) vs heterozygotes (2.1%) or noncarriers (1.1%).

Please see additional Select Safety Information throughout.
Please see full Prescribing Information for LEQEMBI, including Boxed WARNING.

LEQEMBI®
(lecanemab-irmb)

Act urgently to identify, screen, and refer the appropriate patients for LEQEMBI®[1]

There is a critical window at the early symptomatic stages of AD for treatment with LEQEMBI, so it's important to refer to a specialist as soon as possible to confirm if AD is the cause of cognitive decline.[1]



RACHEL, LEQEMBI PATIENT SINCE 2024.

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AD, Alzheimer's disease.

Learn more at the LEQEMBI website

SELECT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

Monitoring and Dose Management Guidelines

Baseline brain MRI and periodic monitoring with MRI are recommended. Enhanced clinical vigilance for ARIA is recommended during the first 14 weeks of treatment. Depending on ARIA-E and ARIA-H clinical symptoms and radiographic severity, use clinical judgment when considering whether to continue dosing or to temporarily or permanently discontinue LEQEMBI. If a patient experiences ARIA symptoms, 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.

HYPERSENSITIVITY REACTIONS

Hypersensitivity reactions, including angioedema, bronchospasm, and anaphylaxis, have occurred with LEQEMBI. Promptly discontinue the infusion upon the first observation of any signs or symptoms consistent with a hypersensitivity reaction and initiate appropriate therapy.

INFUSION-RELATED REACTIONS (IRRs)

IRRs were observed—LEQEMBI: 26%; placebo: 7%—and most cases with LEQEMBI (75%) occurred with the first infusion. IRRs were mostly mild (69%) or moderate (28%). Symptoms included fever and flu-like symptoms (chills, generalized aches, feeling shaky, and joint pain), nausea, vomiting, hypotension, hypertension, and oxygen desaturation.

IRRs can occur during or after the completion of infusion. In the event of an IRR during the infusion, the infusion rate may be reduced or discontinued, and appropriate therapy initiated as clinically indicated. Consider prophylactic treatment prior to future infusions with antihistamines, acetaminophen, nonsteroidal anti-inflammatory drugs, or corticosteroids.

ADVERSE REACTIONS

- The most common adverse reactions reported in ≥5% with LEQEMBI infusion every 2 weeks and ≥2% higher than placebo were IRRs (LEQEMBI: 26%; placebo: 7%), ARIA-H (LEQEMBI: 14%; placebo: 8%), ARIA-E (LEQEMBI: 13%; placebo: 2%), headache (LEQEMBI: 11%; placebo: 8%), superficial siderosis of central nervous system (LEQEMBI: 6%; placebo: 3%), rash (LEQEMBI: 6%; placebo: 4%), and nausea/vomiting (LEQEMBI: 6%; placebo: 4%)
- The safety profile of subcutaneous LEQEMBI was similar to intravenous infusion. Subcutaneous dosing was associated with mostly localized (erythema, induration, swelling, heat, pain, pruritus, rash, ecchymosis, nodule, and hematoma) and less frequent systemic (headache, chills, fever, and fatigue) injection-related reactions, majority at first dose when initiating therapy. Localized reactions that were recurrent and/or delayed were observed. Severe localized reactions and cases leading to dose discontinuation or interruption occurred.

LEQEMBI (lecanemab-irmb) is available:

- Intravenous infusion: 100 mg/mL
- Subcutaneous injection: 200 mg/mL

Please see additional Select Safety Information throughout.
Please see full Prescribing Information for LEQEMBI, including Boxed WARNING.

References: 1. Alzheimer's Association. 2025 Alzheimer's disease facts and figures. *Alzheimers Dement*. 2025;21:e70235. doi:10.1002/alz.70235 **2.** Cordell CB, Borson S, Boustani M, et al. Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting. *Alzheimers Dement*. 2013;9(2):141-150. **3.** Zhao Q, Du X, Chen W, Zhang T, Xu Z. Advances in diagnosing mild cognitive impairment and Alzheimer's disease using ^{11}C-PIB- PET/CT and common neuropsychological tests. *Front Neurosci*. 2023;17:1216215. doi:10.3389/fnins.2023.1216215 **4.** Galvin JE, Roe CM, Powlishta KK, et al. The AD8: a brief informant interview to detect dementia. *Neurology*. 2005;65(4):559-564. **5.** Tariq SH, Tumosa N, Chibnall JT, Perry MH 3rd, Morley JE. Comparison of the Saint Louis University mental status examination and the mini-mental state examination for detecting dementia and mild neurocognitive disorder—a pilot study. *Am J Geriatr Psychiatry*. 2006;14(11):900-910. **6.** Porsteinsson AP, Isaacson RS, Knox S, Sabbagh MN, Rubino I. Diagnosis of early Alzheimer's disease: clinical practice in 2021. *J Prev Alzheimers Dis*. 2021;8(3):371-386. **7.** National Library of Medicine. Calcium blood test. MedlinePlus. Updated December 2, 2024. Accessed April 3, 2025. https://medlineplus.gov/lab-tests/calcium-blood-test/ **8.** Case Western Reserve University. Computed tomography (CT) of the brain: basics. Updated July 4, 2016. Accessed July 9, 2025. https://case.edu/med/neurology/NR/CTBasics.htm **9.** Angioni D, Delrieu J, Hansson O, et al. Blood biomarkers from research use to clinical practice: what must be done? A report from the EU/US CTAD task force. *J Prev Alzheimers Dis*. 2022;9(4):569-579.

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