

# ANTI AMYLOID CLINIC (AAT CLINIC) INFORMATION FOR DOCTORS

## Referring Patients for Anti-Amyloid Therapy — Lecanemab (Leqembi®) and Donanemab (Kisunla®)

**This information is for doctors considering referral.**

**This letter outlines who may be suitable, what to consider before referring, and what to expect from our clinic.**

### WHAT ARE THESE TREATMENTS?

Lecanemab and Donanemab are monoclonal antibodies that target and clear amyloid plaques from the brain. They modestly slow the rate of cognitive and functional decline — they are not a cure and do not reverse existing impairment. Patients and families should understand this before referral. Clinical trials demonstrated approximately 27% slowing of decline over 18 months with Lecanemab (Clarity AD) and approximately 35% slowing of decline over 76 weeks with donanemab (TRAILBLAZER-ALZ 2). Both agents are given by intravenous infusion and require mandatory serial MRI monitoring throughout treatment.

### WHO MAY BE SUITABLE?

The ideal candidate is a patient with MCI due to AD or mild AD dementia who remains largely functionally independent. Moderate or severe dementia is outside the treatment window.

	Lecanemab	Donanemab
Age range (trial criteria)	50–90 years	60–85 years
MMSE	≥22	≥20
CDR Global Score	0.5–1.0	0.5–1.0
Amyloid confirmation	Required	Required
APOE ε4 genotyping	Strongly recommended	Required

Patients with other primary dementia diagnoses, including Lewy body dementia, frontotemporal dementia, and vascular dementia — are not eligible

# FIVE THINGS TO CONSIDER BEFORE REFERRING

## 1. Is the diagnosis early-stage AD?

Patients must have a clinical diagnosis of MCI due to AD or mild AD dementia, with objective impairment on standardised cognitive testing. Subjective memory complaints alone are not sufficient. If you are uncertain about diagnosis or staging, our clinic welcomes early contact — we can assist in determining whether further workup is indicated.

For GPs: If you are seeing a patient with early memory concerns and no specialist involvement yet, please refer to a neurologist, geriatrician, or old age psychiatrist for diagnostic confirmation before or alongside contacting our clinic.

For specialists: Please include MMSE scores from a recent assessment. Patients MMSE <20 are outside the eligible window.

## 2. Has amyloid been confirmed?

Amyloid positivity must be confirmed before treatment can be initiated. Accepted methods are:

- Amyloid PET scan (preferred where available)
- CSF biomarkers — A $\beta$ 42/40 ratio and/or p-tau/A $\beta$ 42
- Blood-based biomarkers (e.g., plasma p-tau217) — emerging and promising but not yet validated as standalone confirmation; should be integrated with clinical context, p-tau 181 blood test for AD exclusion.

For GPs: If amyloid testing has not been arranged, please indicate this on the referral. Our clinic can assist in coordinating appropriate testing, or we can advise on the most appropriate pathway in your area.

For specialists: Please attach PET or CSF reports with your referral.

### 3. Has a recent brain MRI been performed?

A brain MRI within the preceding 6 months is required before treatment can begin due to the risk of Amyloid-Related Imaging Abnormalities (ARIA) — inflammatory and haemorrhagic changes in the brain that can occur during treatment. MRI needs to be specifically requested on a 3 T Machine with a GRE and SWI and coronal views. Its needs to be accessed by the patient with ease especially an issue in remote regions. Radiology readers need to be understanding of the treatment as well and perform an ARIA radiology assessment.

The following MRI findings are significant safety concerns and may preclude treatment:

- More than 4 cerebral microhaemorrhages
- Any macrohemorrhage >1 cm
- Superficial siderosis
- Severe white matter hyperintensities (Fazekas grade 3)
- Features of Cerebral Amyloid Angiopathy (CAA)

For GPs: If your patient has not had a recent MRI, a referral for a brain MRI with a clinical indication of early AD / pre-treatment assessment for anti-amyloid therapy is appropriate. Please include the report with your referral.

For specialists: If any of the above features are present, please do not exclude the patient without discussion — include the report and clinical context, and our team will review on a case-by-case basis.

### 4. Has APOE ε4 genotyping been arranged?

APOE genotyping is essential for individualised ARIA risk counselling. ARIA risk — particularly serious and symptomatic ARIA — increases substantially with APOE ε4 carrier status:

APOE ε4 Status	ARIA-E Risk	ARIA-H Risk
Non-carrier	~5%	~12%
Heterozygote (ε4/ε3)	~11%	~14%
Homozygote (ε4/ε4)	~33%	~39%

APOE ε4/ε4 homozygotes are not always automatically excluded, but require particularly careful informed consent and clinical judgement and high risk. Please include the genotyping result with your referral if available.

## 5. Are there any safety concerns?

Please review the following before referring:

Safety Flag	Action
Anticoagulant therapy (warfarin, NOAC, heparin)	Contact clinic before referring – concurrent use significantly increases haemorrhagic ARIA risk and is generally not recommended
Recent stroke or TIA (<12 months)	Exclusion criterion – defer referral
Active malignancy	Exclusion criterion
Poorly controlled hypertension	Optimise BP before or alongside referral
MRI contraindication	Patients unable to undergo serial MRI cannot be safely monitored and are not eligible
Non-AD dementia confirmed	Not eligible – do not refer

Aspirin and standard antiplatelet therapy may be continued on a case-by-case basis and are not an automatic exclusion, but would be considered extremely cautiously.

## THE IMPORTANCE OF A CARE PARTNER

A reliable care partner who is able to attend clinic appointments and assist with monitoring is strongly recommended for both agents. Please consider this when identifying suitable patients, particularly those who live alone or have limited support networks.

## WHAT DOES THE REFERRAL PROCESS INVOLVE?

Once received, our multidisciplinary team will:

- Review all submitted clinical information and determine eligibility
- Contact you and the patient to discuss any outstanding workup
- Arrange a clinic appointment for shared decision-making with the patient and care partner — covering realistic expectations of treatment benefit, ARIA risk, monitoring commitments, and access arrangements
- Confirm a treatment plan and coordinate pre-treatment baseline investigations if not already completed

You will receive a written report following our assessment regardless of treatment outcome.

## WHEN TO CONTACT US BEFORE REFERRING

We welcome early contact from any referring clinician who is uncertain about eligibility. Please call or email our intake coordinator if:

- Your patient is on anticoagulant therapy
- MRI findings include possible contraindications
- The patient is an APOE ε4/ε4 homozygote
- You are a GP wishing to discuss whether a patient warrants specialist diagnostic assessment prior to formal referral
- You have any other clinical concerns

### HOW TO REFER

Please complete our referral form - [robinaprivate.com.au/private-practices/memory-clinic-anti-amyloid-therapy/](https://robinaprivate.com.au/private-practices/memory-clinic-anti-amyloid-therapy/)

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