

| <b>Leqembi® (lecanemab-irmb) MRI Confirmation Documentation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                                                             |              |                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|-------------------------------------------------------------|--------------|----------------------------------------------------------|
| Patient Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         | Date of Birth:                                              |              | Gender:                                                  |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         |                                                             |              |                                                          |
| Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Height: | <input type="checkbox"/> inches <input type="checkbox"/> cm | Weight:      | <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Clinical Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |                                                             |              |                                                          |
| Primary Diagnosis Description:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                                                             | ICD-10 Code: |                                                          |
| Allergies: <input type="checkbox"/> NKDA OR (List):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                                                             |              |                                                          |
| <b>Details needed for therapy:</b> <ul style="list-style-type: none"> <li>Brain MRI must be provided prior to the 3<sup>rd</sup>, 5<sup>th</sup>, 7<sup>th</sup>, and 14<sup>th</sup> infusions.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |                                                             |              |                                                          |
| MRI Confirmation Details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         |                                                             |              |                                                          |
| MRI completed on (date): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                                                             |              |                                                          |
| MRI completed prior to (check one): <div style="display: flex; flex-direction: column; align-items: flex-start; margin-top: 10px;"> <div><input type="checkbox"/> 3<sup>rd</sup> infusion</div> <div><input type="checkbox"/> 5<sup>th</sup> infusion</div> <div><input type="checkbox"/> 7<sup>th</sup> infusion</div> <div><input type="checkbox"/> 14<sup>th</sup> infusion</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |                                                             |              |                                                          |
| MRI reviewed on (date): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |                                                             |              |                                                          |
| Plan:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                                                             |              |                                                          |
| <div style="margin-bottom: 10px;"><input type="checkbox"/> May continue dosing as ordered.</div> <input type="checkbox"/> Suspend dosing.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                                                             |              |                                                          |
| <i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                                                             |              |                                                          |
| Prescriber Signature: _____ Date: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                                                             |              |                                                          |
| Prescriber Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |         |                                                             |              |                                                          |
| Prescriber Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         | Phone:                                                      |              | Fax:                                                     |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         | NPI:                                                        |              |                                                          |
| City, State:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Zip:    | Office Contact:                                             |              |                                                          |
| Fax completed form, insurance information, and clinical documentation to: 713-983-4647                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |         |                                                             |              |                                                          |
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