Leqembi® (lecanemab-irmb) MRI Confirmation Documentation

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA OR (List):

Details needed for therapy:

- **Brain MRI must be provided prior to the 3rd, 5th, 7th, and 14th infusions**.

MRI Confirmation Details

MRI completed on (date): _____

MRI completed prior to (check one):

☐ **3rd infusion**

☐ **5th infusion**

☐ **7th infusion**

☐ **14th infusion**

MRI reviewed on (date): _____

Plan:

☐ **May continue dosing as ordered.**

☐ **Suspend dosing.**

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, and clinical documentation (copy of MRI report) to: 713-983-4657

