

Leqembi® (lecanemab-irmb) MRI Confirmation Documentation

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|--|--|----------------|--|---|--|
| 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): | | | | | |
| Details needed for therapy: <ul style="list-style-type: none">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): <input type="checkbox"/> 3 rd infusion <input type="checkbox"/> 5 th infusion <input type="checkbox"/> 7 th infusion <input type="checkbox"/> 14 th infusion | | | | | |
| MRI reviewed on (date): _____ | | | | | |
| Plan: | | | | | |
| <input type="checkbox"/> May continue dosing as ordered. <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, and clinical documentation (copy of MRI report) to: 713-983-4657 | | | | | |
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