

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): ☐ 3 rd infusion ☐ 5 th infusion ☐ 7 th infusion ☐ 14 th infusion					
MRI reviewed on (date): _____					
Plan:					
☐ May continue dosing as ordered. ☐ 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:	
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