[Physician's Letterhead, Including Tax ID]

[Date]

[Payer Name]

[Payer Address]

[Payer City, State & ZIP]

Re: Authorization for treatment with LEQEMBI® (lecanemab-irmb) for:

[Patient Name]

[Patient DOB]

[Policy/Member ID Number]

[Group Number]

To Whom It May Concern:

Authorization for Treatment with LEQEMBI® (lecanemab-irmb) for:

I am submitting this letter to document the medical necessity of LEQEMBI® for [intravenous/subcutaneous] use for [Patient Name]. LEQEMBI is indicated for [insert FDA-approved indication].

I have evaluated my patient's clinical symptoms and have provided a summary below:

[Patient Name] has been diagnosed with [ICD-10 CM Code; Diagnosis Description as written by the ICD-10 Code] on [Date of Diagnosis].

[Describe the patient's history. Including patient's current condition, symptoms, quality of life and how it is affecting the caregiver/family. Include physician's opinion of prognosis, including:

- Standard patient demographic Information
- Test performed for beta amyloid pathology confirmation and date (i.e. CSF or amyloid PET scan)
- Baseline MRI findings and date
- Validated cognitive tool – cognitive test, score, and date
- Validated functional tool – functional test, score, and date
- If performed, APOE4 test result and date]

Based on the information provided above and my clinical opinion, LEQEMBI is medically necessary and is an appropriate drug for my patient. Enclosed is the full prescribing information for LEQEMBI, including Boxed WARNING.

The following additional information is enclosed:

- ☐ Copies of patient medical records
- ☐ LEQEMBI Prescribing Information, including Boxed WARNING
- ☐ Advocacy Letter from Patient or Caregiver

Please approve coverage for LEQEMBI for [Patient Name] as recommended. Thank you for your prompt attention to this matter. If I can provide any additional information, please contact me.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Sincerely,
[Physician Name]
[Physician Specialty]
[Physician Signature]

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