[Physician's letterhead]

[Date]

[Name of Health Insurance Company]
[PO Box or Street Address]
[City], [State] [Zip Code]

Re: Authorization for treatment with LEQEMBI® (lecanemab-irmb) for [Patient Name]
Policy Number: [ ]
Group Number: [ ]
Date of Birth: [ ]

To whom it may concern:

I am submitting this letter to document the medical necessity of LEQEMBI® (lecanemab-irmb) injection, for intravenous use for [Patient Name]. LEQEMBI is indicated for the treatment of [insert FDA-approved indication]. [Patient Name] has been diagnosed with [ICD-10 CM Code] [Diagnosis] [Include a description of investigation leading to diagnosis and any treatment that followed the diagnosis.]

[Describe the patient's history, including diagnostic test results, previous and current treatment regimens, and their outcomes.]

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

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]
[Signature]

Enclosures:

- Copies of Patient Medical Records
- LEQEMBI Prescribing Information, including Boxed WARNING

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