USFHP Prior Authorization Request Form for

lecanemab-irmb (Leqembi IQLIK)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

1. Is the requested medication being prescribed by a neurologist, psychiatrist, or specialist in geriatric medicine?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ Alzheimer's disease – Proceed to question **3** ☐ Other diagnosis – **STOP – Coverage not approved**	
3. Is the patient being treated for mild cognitive impairment OR mild dementia?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has documentation been submitted to confirm that the patient has completed 18 months of intravenous lecanemab (Leqembi) treatment AND achieved maintenance dosing? **NOTE:** Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Prescriber must submit medical documentation to confirm completion of 18 months of initial treatment with intravenous lecanemab (Leqembi).	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____