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New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a confirmed diagnosis of mild cognitive impairment (MCI) due to Alzheimer's Disease or mild Alzheimer's Disease? ☐ Yes ☐ No
   - Clinical Dementia Rating (CDR) – Global Score of 0.5 to 1 ☐ Yes ☐ No
   - Objective evidence of cognitive impairment at screening ☐ Yes ☐ No
   - Mini-Mental Status exam (MMSE) score between 22 and 30 (inclusive) ☐ Yes ☐ No
   - Positron Emission Tomography (PET) is positive for beta amyloid plaque or cerebrospinal fluid assessment of amyloid beta (1–42) or FDA-approved test to confirm diagnosis ☐ Yes ☐ No

Fax to Prime Therapeutics Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-314-8101

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Review Date: 06/29/2023

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PATIENT LAST NAME:

PATIENT FIRST NAME:

2. Have the following conditions been ruled out: vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus? ☐ Yes ☐ No
3. Has the patient had a stroke or transient ischemic attack or unexplained loss of consciousness in the past 12 months? ☐ Yes ☐ No
4. Has the patient had a brain hemorrhage, bleeding disorder, cerebrovascular abnormality, or cardiovascular conditions (e.g., unstable angina, myocardial infarction, advanced congestive heart failure, clinically significant conduction abnormalities) in the past 12 months? ☐ Yes ☐ No
5. Is the patient on an anti-platelet, anticoagulant, or anti-thrombin medication? ☐ Yes ☐ No
6. Is the prescriber a neurologist or gerontologist **or** has a neurologist or gerontologist been consulted? ☐ Yes ☐ No
7. Has the patient received a baseline magnetic resonance imaging (MRI) within the past 12 months? ☐ Yes ☐ No
8. (Aduhelm® only): Will the patient receive a brain MRI prior to the 5th, 7th, 9th, and 12th doses? ☐ Yes ☐ No
9. (Leqembi® only): Will the patient receive a brain MRI prior to the 5th, 7th, and 14th doses? ☐ Yes ☐ No
10. Has the patient experienced any of the following? ☐ Yes ☐ No
    - Pre-treatment localized superficial siderosis
    - ≥ 10 brain microhemorrhages
    - Brain hemorrhage > 1 cm
11. Has a baseline assessment been completed with at least one of the following? ☐ Yes ☐ No
    - MMSE
    - Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAP-Cog-13]
    - Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI]
      Clinical Dementia Rating-Sum of Boxes [CDR-SB]
12. Has the prescriber informed the patient of the known or potential risks and minimal established clinical benefit based on clinical trials to date with treatment? ☐ Yes ☐ No

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13. **For renewals (every 6 months)**: Has the patient demonstrated stability, improvement, or slowed rate of progression in one of the following assessments? ☐ Yes ☐ No
    - ADAS-Cog 13
    - ADCS-ADL-MCI
    - MMSE
    - CDR-SB

    Renewal assessment results:

14. Has the patient progressed to moderate or severe Alzheimer's Disease? ☐ Yes ☐ No
15. Has the patient continued dosing at 10 mg/kg every 4 weeks (Aduhelm®) or every 2 weeks (Leqembi™)? ☐ Yes ☐ No
16. Has the patient received ongoing MRI monitoring as directed in the package insert (questions 8 or 9 above)? ☐ Yes ☐ No
17. Did the MRI show > 10 new incident microhemorrhages or ≥ 2 focal areas of superficial siderosis? ☐ Yes ☐ No
18. Will a follow-up MRI be performed to assess stability? ☐ Yes ☐ No
19. Do the benefits outweigh the risks based on the MRI results? ☐ Yes ☐ No

Please provide any additional information that would help in the decision-making process. **If additional space is needed, please use a separate sheet.**

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I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Facility where infusion is to be provided: _____

Medicaid provider number of facility: _____

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