



**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:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

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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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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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. (Kisunla™ only): Will the patient receive a brain MRI prior to the 2nd, 3rd, 4th, and 7th doses? Yes No
11. Has the patient experienced any of the following? Yes No
 - Pre-treatment localized superficial siderosis
 - ≥ 10 brain microhemorrhages
 - Brain hemorrhage > 1 cm
12. 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]
13. 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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14. **For renewals (every 6 months):** Has the patient demonstrated stability, improvement, or slowed Yes No rate of progression in one of the following assessments?

- ADAS-Cog 13
- ADCS-ADL-MCI
- MMSE
- CDR-SB

Renewal assessment results:

15. Has the patient progressed to moderate or severe Alzheimer’s Disease? Yes No

16. Has the patient continued dosing at 10 mg/kg every 4 weeks (Aduhelm®) or every 2 weeks (Leqembi™) or 1,400 mg every 4 weeks (Kisunla™)? Yes No

17. Has the patient received ongoing MRI monitoring as directed in the package insert (questions 8–10 above)? Yes No

18. Did the MRI show > 10 new incident microhemorrhages or ≥ 2 focal areas of superficial siderosis? Yes No

19. Will a follow-up MRI be performed to assess stability? Yes No

20. 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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