



**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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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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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 Magellan Rx 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 5<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup>, and 12<sup>th</sup> doses?  Yes  No
9. (Leqembi® only): Will the patient receive a brain MRI prior to the 5<sup>th</sup>, 7<sup>th</sup>, and 14<sup>th</sup> 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  Yes  No rate of progression in one of the following assessments?

- 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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**PATIENT FIRST NAME:**

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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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