Aduhelm

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)* ❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)* ❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the diagnosis?

❒ Alzheimer's disease (AD), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Aduhelm SGM 4776-A – 02/2024.

2. What type of request is this for?

❒ Initiation, new start request, *Continue to 3*

❒ Continuation request of a previously granted approval by Aetna/CVS Health, *Continue to 25*

❒ Continuation request, no previous approval by Aetna/CVS Health, *Continue to 4*

3. Is the patient currently enrolled in a randomized controlled trial conducted under an investigational new drug (IND) application or National Institutes of Health (NIH)-supported trial? ***ACTION REQUIRED***: If Yes, please attach documentation of enrollment (e.g., trial number, name of trial, enrollment form) in an IND or NIH-supported trial. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 5*

4. Does patient continue to be enrolled in a randomized controlled trial conducted under an investigational new drug (IND) application or National Institutes of Health (NIH)-supported trial? ***ACTION REQUIRED***: If Yes, please attach documentation of enrollment (e.g., trial number, name of trial, enrollment form) in an IND or NIH-supported trial. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 26*
❒ No, *Continue to 5*

5. Have other forms of suspected neurodegenerative etiology other than Alzheimer's disease been ruled out, including but not limited to frontotemporal lobar degeneration (FTLD) or Lewy body disease (i.e., meeting consensus criteria for possible or probable dementia with Lewy bodies)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the patient receiving therapeutic anticoagulation therapy (e.g., anticoagulants, antiplatelets), except for aspirin at the prophylaxis dose or less (no more than 325 mg daily)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have a history of transient ischemic attacks (TIA), stroke, or seizures within the past 12 months?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have a bleeding disorder that is not under adequate control (including a platelet count <50,000 or international normalized ratio [INR] > 1.5)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the requested drug be used in combination with any other amyloid beta-directed antibodies (e.g., lecanemab)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is this medication being prescribed by or in consultation with a geriatrician, neurologist, psychiatrist or neuropsychiatrist?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient 50 years of age or older?
❒ Yes, *Continue to 14*
❒ No, *Continue to 12*

12. Has genetic testing been completed to confirm the patient has a genetic mutation in the amyloid precursor protein (APP), presenilin-1 (PSEN1), or presenilin-2 (PSEN2)? ***ACTION REQUIRED***: If Yes, please attach testing results documenting a mutation in the amyloid precursor protein (APP), presenilin-1 (PSEN-1) or preseline-2 (PSEN2). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 13*

13. Is there clinical documentation to support the patient has early onset Alzheimer's disease? ***ACTION REQUIRED***: If Yes, please attach clinical documentation supporting early onset Alzheimer's disease. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Does the patient have mild cognitive impairment due to Alzheimer's disease (AD) or mild Alzheimer's disease (AD)? ***ACTION REQUIRED***: If Yes, please attach medical records or chart notes documenting diagnosis of mild impairment due to Alzheimer's disease (AD) or mild Alzheimer's disease (AD). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have objective evidence of cognitive impairment at baseline?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Based on clinical and cognitive evaluation of the patient, which of the following characteristics does the patient exhibit as objective evidence of mild cognitive impairment at baseline?
❒ Cognitive concern reflecting a change in cognition reported by patient or information or clinician (i.e., historical or observed evidence of decline over time), *Continue to 17*
❒ Objective evidence of impairment in one or more cognitive domains, typically including memory (i.e., formal or bedside testing to establish level of cognitive function in multiple domains), *Continue to 17*
❒ Preservation of independence in functional abilities, *Continue to 17*
❒ Not demented, *Continue to 17*
❒ All of the above, *Continue to 17*
❒ None of the above, *Continue to 17*

17. Which of the following assessment tools have been completed at baseline?

❒ Clinical Dementia Rating Global Score (CDR-GS), *Continue to 18*

❒ Mini-Mental Status Examination (MMSE), *Continue to 19*

❒ Montreal Cognitive Assessment (MoCA), *Continue to 20*

❒ None of the above, *No Further Questions*

18. What is the patient's Clinical Dementia Rating Global Score (CDR-GS)? ***ACTION REQUIRED***: Please attach baseline assessment tool for the Clinical Dementia Rating Global score (CDR-GS).

❒ 0 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ 0.5 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ 1 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ 2 or more ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ Unknown ***ACTION REQUIRED***: *Submit supporting documentation, , Continue to 21*

19. What is the patient's Mini-Mental Status Examination (MMSE) Score? ***ACTION REQUIRED***: Please attach baseline assessment tool for the Mini-Mental Status Exam (MMSE).

❒ Less than 21 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ 21 - 30 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ Unknown ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

20. What is the patient's Montreal Cognitive Assessment (MoCA) Score? ***ACTION REQUIRED***: Please attach baseline assessment tool for the Montreal Cognitive Assessment Score (MoCA).

❒ Greater than or equal to 16 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ 15 or less ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ Unknown ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

21. Has the patient had a positron emission tomography (PET) scan confirming the presence of amyloid pathology? ***ACTION REQUIRED***: If Yes, please attach baseline PET scan results. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 23*

❒ No, *Continue to 22*

22. Has a lumbar puncture been completed to confirm at least one of the following detected in cerebrospinal fluid (CSF) as determined by lab assay? ***ACTION REQUIRED***: If Yes, please attach lumbar puncture results.

❒ Yes, presence of elevated phosphorylated tau (P-tau) protein and/or elevated total tau (T-tau) protein and reduced beta amyloid-42 (AB42) ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 23*

❒ Yes, low AB42/AB40 ratio ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 23*

❒ Yes, elevated P-Tau/AB42 ratio ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 23*

❒ Yes, elevated T-Tau/AB42 ratio ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 23*

❒ No, *Continue to 23*

23. Has the patient had a recent brain magnetic resonance imaging (MRI) within one year, prior to initiating treatment? ***ACTION REQUIRED***: If Yes, please attach recent (within one year) MRI results. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is this a continuation request?
❒ Yes, *Continue to 29*
❒ No, *No Further Questions*

25. Does the patient continue to be enrolled in a randomized controlled trial conducted under an investigational new drug (IND) application or National Institutes of Health (NIH)-supported trial? ***ACTION REQUIRED***: If Yes, please attach documentation of enrollment (e.g., trial number, name of trial, enrollment form) in an IND or NIH-supported trial. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 26*
❒ No, *Continue to 29*

26. How many months of therapy on the requested medication has the patient completed? Indicate in months.
❒ _____months, *Continue to 27*
❒ Unknown, *Continue to 27*

27. Please enter the start date of therapy.
❒ _____ MM/DD/YY, *Continue to 28*
❒ Unknown, *Continue to 28*

28. Which of the following applies to this continuation request?
❒ The patient has completed 6 months of therapy (first reauthorization request after initial 6-month approval period), *No Further Questions*
❒ The patient has completed two rounds of therapy (second round of reauthorization after 12-17 months of therapy) *No Further Questions*
❒ The patient has completed 18 months of therapy or more, *No Further Questions*

29. How many months of therapy on the requested medication has the patient completed?
❒ _____months, *Continue to 30*
❒ Unknown, *Continue to 30*

30. Please enter the start date of therapy.
❒ _____ MM/DD/YY, *Continue to 31*
❒ Unknown, *Continue to 31*

31. Which of the following applies to this continuation request?
❒ The patient has completed 6 months of therapy (first reauthorization request after initial 6-month approval period), *Continue to 32*

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org.

❒ The patient has completed two rounds of therapy (second round of reauthorization after 12-17 months of therapy), *Continue to 38*

❒ The patient has completed 18 months of therapy or more, *Continue to 44*

32. Has the patient been evaluated for evidence of amyloid-related imaging abnormalities (ARIA) on MRI prior to the 5th dose (first dose of 6 mg/kg)? ***ACTION REQUIRED***: Please attach brain magnetic resonance imaging results prior to the 5th dose. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Has the patient been evaluated for evidence of amyloid-related imaging abnormalities (ARIA) on MRI prior to the 7th dose (first dose of 10 mg/kg)? ***ACTION REQUIRED***: Please attach brain magnetic resonance imaging results prior to the 7th dose. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Does the patient have evidence of ARIA?
❒ Yes, *Continue to 35*
❒ No, *No Further Questions*

35. Based on the MRI results, which of the following describes the radiographic evidence of ARIA?

❒ The patient has radiographic evidence of ARIA-E, *Continue to 36*

❒ The patient has radiographic evidence of ARIA-H, *Continue to 37*

36. Identity which of the following results pertains to the patient's radiographic evidence of ARIA E.
❒ The patient has mild ARIA-E on MRI and is asymptomatic or has mild clinical symptoms, *No Further Questions*

❒ The patient has mild ARIA-E on MRI and has moderate or severe clinical symptoms, *No Further Questions*
❒ The patient has moderate ARIA-E on MRI and is asymptomatic or has, mild, moderate, or severe clinical symptoms, *No Further Questions*
❒ The patient has severe ARIA-E on MRI and is asymptomatic or has, mild, moderate, or severe clinical symptoms, *No Further Questions*

37. Identity which of the following results pertains to the patient's radiographic evidence of ARIA H.

❒ The patient has mild ARIA-H on MRI and is asymptomatic, *No Further Questions*

❒ The patient has mild ARIA-H on MRI and is symptomatic, *No Further Questions*

❒ The patient has moderate ARIA-H on MRI and is asymptomatic or symptomatic, *No Further Questions*

❒ The patient has severe ARIA-H on MRI and is asymptomatic or symptomatic, *No Further Questions*

38. Has the patient been evaluated for evidence of amyloid-related imaging abnormalities (ARIA) on MRI prior to the 9th dose (third dose of 10 mg/kg)? ***ACTION REQUIRED***: Please attach brain magnetic resonance imaging results prior to the 9th dose. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Has the patient been evaluated for evidence of amyloid-related imaging abnormalities (ARIA) on MRI prior to the 12th dose (sixth dose of 10 mg/kg) ***ACTION REQUIRED***: Please attach brain magnetic resonance imaging results prior to the 12th dose. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Does the patient have evidence of ARIA?
❒ Yes, *Continue to 41*
❒ No, *No Further Questions*

41. Based on the MRI results, which of the following describes the radiographic evidence of ARIA?

❒ The patient has radiographic evidence of ARIA-E, *Continue to 42*

❒ The patient has radiographic evidence of ARIA-H, *Continue to 43*

42. Identity which of the following results pertains to the patient's radiographic evidence of ARIA E.
❒ The patient has mild ARIA-E on MRI and is asymptomatic or has mild clinical symptoms, *No Further Questions*

❒ The patient has mild ARIA-E on MRI and has moderate or severe clinical symptoms, *No Further Questions*
❒ The patient has moderate ARIA-E on MRI and is asymptomatic or has, mild, moderate, or severe clinical symptoms, *No Further Questions*
❒ The patient has severe ARIA-E on MRI and is asymptomatic or has, mild, moderate, or severe clinical symptoms, *No Further Questions*

43. Identity which of the following results pertains to the patient's radiographic evidence of ARIA H.

❒ The patient has mild ARIA-H on MRI and is asymptomatic, *No Further Questions*

❒ The patient has mild ARIA-H on MRI and is symptomatic, *No Further Questions*

❒ The patient has moderate ARIA-H on MRI and is asymptomatic or symptomatic, *No Further Questions*
❒ The patient has severe ARIA-H on MRI and is asymptomatic or symptomatic symptoms, *No Further Questions*

44. Has the patient had a positive clinical response as evidenced by stabilization in score of any of the following measures?

❒ Yes, Clinical Dementia Rating Global Score (CDR-GS), *Continue to 45*

❒ Yes, Mini-Mental Status Examination (MMSE), *Continue to 46*

❒ Yes, Montreal Cognitive Assessment (MoCA), *Continue to 47*

❒ No, None of the above, *No Further Questions*

45. What is the patient's Clinical Dementia Rating Global Score (CDR-GS)? ***ACTION REQUIRED***: Please attach medical records (e.g., chart notes) documenting the most recent (less than 1 month prior to continuation request) result for the Clinical Dementia Rating Global Score (CDR-GS).

❒ 0 ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ 0.5 ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ 1 ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ 2 or more ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ Unknown ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

46. What is the patient's Mini-Mental Status Examination (MMSE) Score? ***ACTION REQUIRED***: Please attach medical records (e.g., chart notes) documenting the most recent (less than 1 month prior to continuation request) result for the Mini-Mental Status Exam (MMSE).

❒ Less than 21 ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ 21 - 30 ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ Unknown, *No Further Questions*

47. What is the patient's Montreal Cognitive Assessment Score (MoCA)? ***ACTION REQUIRED***: Please attach medical records (e.g., chart notes) of the most recent (less than 1 month prior to continuation request) for the Montreal Cognitive Assessment Score (MoCA).

❒ Greater than or equal to 16 ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ 15 or less ***ACTION REQUIRED****: Submit supporting documentation*, *No Further Questions*

❒ Unknown, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756