Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Aduhelm® (aducanumab)
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Initial Authorization:

❑ The recipient has a documented diagnosis of one of the following:
- Diagnosis of mild cognitive impairment due to Alzheimer's disease
- Diagnosis of probable Alzheimer's disease dementia

❑ The recipient has TWO of the following:
- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) score $\leq$ 85
- Mini-Mental State Examination (MMSE) score of 24-30
- Montreal Cognitive Assessment (MoCA) score of 19-25

❑ Documentation of beta-amyloid protein deposition, as evidenced by ONE of the following:
- Positive amyloid positron emission tomography (PET) scan
- Attestation that the patient does not have access to amyloid PET scanning AND cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., Aβ42 level, Aβ42:Aβ40 ratio)

❑ Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.) have been ruled out.

❑ ALL of the following:
- Patient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less)
- Patient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment
- Patient does NOT have a history of relevant brain hemorrhage, bleeding disorder, and cerebrovascular abnormalities in last 6 months

❑ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment to rule out other causes (e.g., stroke, small vessel disease, tumor).

❑ Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIAE and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting.

❑ Prescribed by a neurologist, geriatrician or geriatric psychiatrist, or other expert in the disease state.

Reauthorization:

- ❑ The recipient has a documented diagnosis of one of the following:
  - Diagnosis of mild cognitive impairment due to Alzheimer's disease
  - Diagnosis of probable Alzheimer's disease dementia
- ❑ The recipient has TWO of the following:
  - Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
  - Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) score $\leq$ 85
  - Mini-Mental State Examination (MMSE) score of 24-30
  - Montreal Cognitive Assessment (MoCA) score of 19-25
- ❑ Follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy to show BOTH of the following:
  - Less than 10 new incident microhemorrhages of mild cognitive impairment due to Alzheimer's disease
  - 2 or less focal areas of superficial siderosis of probable Alzheimer's disease dementia
- ❑ If 10 or more new incident microhemorrhages or greater than 2 focal areas of superficial siderosis are present then BOTH of the following:
  - Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances)
  - Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H)
- ❑ Prescribed by a neurologist, geriatrician or geriatric psychiatrist, or other expert in the disease state.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.