AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Aduhelm

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Does the beneficiary have mild cognitive impairment due to Alzheimer's Disease or mild Alzheimer's Dementia? Yes___ No___
2. Has the beneficiary received all of the tests listed below?
   a. Clinical Dementia Rating (CDR) -Global Score of 0.5 Yes___ No___
   b. Objective evidence of cognitive impairment at screening Yes___ No___
   c. Mini-Mental Status Exam (MMSE) score between 24 and 30 (inclusive) OR equivalent tool indicating MCI or mild dementia (NOTE: range of scores may be adjusted based on educational status of patient) Yes___ No___
   d. Positron Emission Tomography (PET) scan is positive for amyloid beta plaque or Cerebrospinal Fluid Test (collected via lumbar puncture) is positive for amyloid Yes___ No___
3. Is the beneficiary age 50 or older? Yes___ No___
4. Has the beneficiary undergone testing to rule out reversible causes of dementia? Yes___ No___
5. Has the beneficiary had an assessment including a review of current medications as a cause of intellectual decline? Yes___ No___
6. Has the beneficiary had a recent (within one year) brain MRI prior to beginning treatment? Yes___ No___
7. Has the Prescriber assessed and documented baseline disease severity utilizing an objective measure/tool? Yes___ No___
8. Does the Beneficiary have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis? Yes___ No___
9. Has the beneficiary had a failure of or inability to tolerate at least one other preferred cholinesterase inhibitor Alzheimer therapy for at least four months? Yes___ No___
10. Does the provider attest to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg)? Yes___ No___
11. Does the beneficiary have hypersensitivity to any components of Aduhelm? Yes___ No___
12. Is Aduhelm being prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406