AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Leqembi

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

Initial Approval:

1. Is the beneficiary 18 years of age or older? Yes___ No___
2. Does the beneficiary have a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild Alzheimer's dementia? Yes___ No___
3. Does the beneficiary have a Clinical Dementia Rating (CDR)-Global score of 0.5 to 1? Yes___ No___
4. Does the beneficiary have a Memory Box score ≥ 0.5? Yes___ No___
5. Does the beneficiary have a Montreal Cognitive Assessment (MoCA) score of 18 to 25 (inclusive) OR equivalent tool indicating MCI or mild dementia (NOTE: range of scores may be adjusted based on educational status of patient)? Yes___ No___
6. Does the beneficiary have objective evidence of cognitive impairment at screening? Yes___ No___
7. Does the beneficiary have a positron emission tomography (PET) scan or cerebrospinal fluid (CSF) assessment of amyloid beta (1-42) that is positive for amyloid beta plaque? Yes___ No___
8. Does the prescriber attest that other conditions causing similar symptoms have been ruled out (e.g., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus)? Yes___ No___
9. Does the beneficiary have risk factors for intracerebral hemorrhage (e.g., prior cerebral hemorrhage > 1 cm in greatest diameter, more than 4 microhemorrhages, superficial siderosis, evidence of vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel, or white matter disease)? Yes___ No___
10. Has the beneficiary had a stroke, transient ischemia attack (TIA), or seizure in the last 12 months? Yes___ No___
11. Has the beneficiary demonstrated clinically significant and unstable psychiatric illness in the last 6 months? Yes___ No___
12. Is the beneficiary currently receiving anti-platelet agents (with the exception of prophylactic aspirin or clopidogrel), anticoagulants (e.g., Factor Xa inhibitors), or anti-thrombins (e.g., heparin)? Yes___ No___
13. Has the beneficiary had a recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment? Yes___ No___
14. Has the baseline disease severity been assessed using an objective measure/tool (e.g., MoCA, Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-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])? Yes___ No___
15. Is Leqembi being prescribed by or in consultation with a neurologist, geriatrician, or geriatric psychiatrist? Yes___ No___

Reauthorization: (Please answer 1-15 above and 1-5 below)

1. Does scoring for the beneficiary on an objective measure/tool (e.g., ADAS-Cog 13; ADCS-ADL-MCI; MMSE; CDR-SB) demonstrate improvement, stability, or slowing of decline in cognitive and/or functional impairment? Yes___ No___
2. Has the beneficiary progressed to moderate or severe Alzheimer's Disease? Yes___ No___
3. Has the beneficiary experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions)? Yes___ No___
4. Has the beneficiary undergone an MRI prior to the 5th, 7th, and 14th infusions to monitor for ARIA with edema (ARIA-E) or ARIA with hemosiderin deposition (ARIA-H)? Yes___ No___
5. Will Leqembi administrations be suspended and not resumed until MRI demonstrates radiographic resolution and stabilization of symptoms in the event of any of the following? Yes___ No___
   a. ARIA-E that is asymptomatic or mildly symptomatic with moderate to severe radiographic severity
   b. ARIA-E with moderate to severe symptoms and any degree of radiographic severity
   c. ARIA-H that is asymptomatic with moderate radiographic severity
   d. ARIA-H with moderate to severe symptoms and any degree of radiographic severity
   e. ARIA-H with severe radiographic severity

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