NEBRASKA MEDICAID & LONG-TERM CARE
Aducanumab (Aduhelm)
Prior Authorization Form for Fee-for-Service

Member Name : _____ Medicaid ID: _____
Member date of birth:_____ Age _____ (must be ≥ 50 years at initiation of treatment)

Ordering Physician (please print) _____ NPI_____
(prescribed by or in consultation with a neurologist, geriatrician). Specialty _____

Physician's Address _____
Physician's Phone _____ Physician's Fax Number _____

HCPCS code _____ units_____ Dose/frequency/duration _ _____

Diagnosis Code:_____ Date of last dose (if reauthorization) _____

Section I: Please complete for INITIAL REQUESTS FOR ADUHELM. The initial authorization period is for 6 months.

1. Indication
   - ☐ Alzheimer's disease (Specify stage of disease)
     - ☐ Mild cognitive impairment ☐ Mild dementia ☐ Other

2. Is the prescriber a neurologist or geriatrics specialist?
   - ☐ Yes
   - ☐ No. Please attach consultation notes from a neurologist or geriatrics specialist addressing the use of the requested agent.

3. Please provide baseline (within the past three months) score of one of the following tests:
   Mini Mental State Exam (MMSE) (please attach a copy of MMSE) Date
   Montreal Cognitive Assessment (MoCA) (please attach a copy of MoCA) Date

4. Does the member have confirmed evidence of clinically significant Alzheimer's disease (AD) neuropathology based on one of the following? If yes, please attach supporting documentation.
   - ☐ Yes, based on Cerebral Spinal Fluid (CSF) biomarkers.
   - ☐ Yes, based on Amyloid positron emission tomography (PET).
   - ☐ No

5. Has the member had a brain magnetic resonance imaging (MRI) in the previous three months?
   - ☐ Yes. Date ☐ No

6. Has the member and/or authorized representative been informed of the known and potential risks and lack of established clinical benefit associated with treatment?
   - ☐ Yes (Member) ☐ Yes (Authorized Representative) ☐ No

7. Does the member have any of the following neurologic conditions?

Probable dementia with Lewy bodies by consensus criteria	☐ Yes	☐ No
Suspected frontotemporal degeneration	☐ Yes	☐ No
Dementia in down syndrome	☐ Yes	☐ No

8. Does the member have significant cerebrovascular disease as established by brain MRI showing any of the following? (Check all that apply)
   - ☐ Yes
     - ☐ Acute or sub-acute hemorrhage
     - ☐ Prior macro-hemorrhage or prior subarachnoid hemorrhage (unless finding is not due to an underlying structural or vascular hemorrhage)
     - ☐ Microhemorrhages
       Please provide number.
     - ☐ Cortical infarct
     - ☐ Lacunar infarct
       Please provide number.
     - ☐ Superficial siderosis
     - ☐ History of diffuse white matter disease
   - ☐ No

9. Does the member have any of the following cardiovascular conditions?

Uncontrolled hypertension	☐ Yes	☐ No
Coronary artery disease (including unstable angina and myocardial infarction)	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Clinically significant carotid atherosclerosis and/or peripheral arterial disease	☐ Yes	☐ No
History of stroke (within the past year)	☐ Yes. Date	☐ No
History of transient ischemic attack (within the past year)	☐ Yes. Date	☐ No
History of unexplained loss of consciousness (within the past year)	☐ Yes. Date	☐ No
Coagulopathy	☐ Yes	☐ No
Requirement for therapeutic anticoagulation and/or dual antiplatelet therapy (not including aspirin ≤ 325 mg/day as monotherapy)	☐ Yes	☐ No

10. Please indicate if the member has any of the following chronic medical conditions (Check all that apply and please describe):
    - ☐ Liver disease:
    - ☐ Pulmonary disease:
    - ☐ Autoimmune disease requiring chronic immunosuppression:
    - ☐ Malignant neoplasm:
    - ☐ Active chronic infection (HIV, HCV):
    - ☐ Diabetes mellitus:
    - ☐ Seizure disorder:
    - ☐ Mood disorder:
    - ☐ Anxiety disorder:
    - ☐ Psychosis:
    - ☐ Other clinically significant condition:

    If the member has any of the above, is the condition(s) controlled?
    - ☐ Yes. Please explain*.
    - ☐ No. Please explain*.

Section II: Please complete for RENEWAL REQUESTS FOR ADUHELM. The re-authorization period is for 6 months.

1. Has the member had follow-up MRIs conducted at the following timeframes? (Check all that apply)
   - ☐ Yes
     - ☐ Week 14 (after 4th infusion, prior to first 6 mg/kg dose). Date of MRI
     - ☐ Week 22 (after 6th infusion, prior to first 10 mg/kg dose). Date of MRI
     - ☐ Week 30 (after 8th infusion, prior to third 10 mg/kg dose). Date of MRI
     - ☐ Week 42 (after 11th infusion, prior to sixth 10 mg/kg dose). Date of MRI
     - ☐ Every six months thereafter. Most recent date of MRI
   - ☐ No

2. Please provide most recent date administered and score of one of the following tests:
   MMSE Score (please attach a copy of MMSE) Date
   MoCA Score (please attach a copy of MoCA) Date
   For a MMSE score < 24 or MoCA score < 15, was the member's rate of decline slower than expected (< two points/year)?
   - ☐ Yes
   - ☐ No. Please provide clinical rationale for continuing therapy*.

3. Does the member have new incident Amyloid-related imaging abnormalities-hemosiderin deposition (ARIA-H) microhemorrhages?
   - ☐ Yes. Please provide the following information below.
     Please indicate number of new incident microhemorrhage(s).
     Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
     Has the member's microhemorrhages been stabilized? ☐ Yes ☐ No
   - ☐ No

4. Does the member have new incident ARIA-H areas of superficial siderosis?
   - ☐ Yes. Please provide the following information below.
     Please indicate number of new incident areas of superficial siderosis.
     Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
     Has the member's superficial siderosis been stabilized? ☐ Yes ☐ No
   - ☐ No

5. Does the member have Amyloid-related imaging abnormalities-edema (ARIA-E)?
   - ☐ Yes. Please provide the following information below.
     Does the member have new ARIA-E? ☐ Yes ☐ No
     Please describe symptoms: ☐ Asymptomatic (no clinical symptoms) ☐ Mild ☐ Moderate ☐ Severe
     What is the severity of ARIA-E on MRI? ☐ Mild ☐ Moderate ☐ Severe
     Has the member's ARIA-E been stabilized? ☐ Yes ☐ No
   - ☐ No

6. Did the member initiate or develop any of the following? (Check all that apply)
   - ☐ Yes
     - ☐ Initiation of anticoagulation
     - ☐ Development of active immune-mediated/autoimmune conditions (e.g., Crohn's disease, systemic lupus erythematosus, aplastic anemia, myasthenia gravis, meningitis/encephalitis)
     - ☐ Initiation of immunomodulatory medications (e.g., cancer immunotherapies, rituximab, azathioprine)
     - ☐ Development of other neurologic conditions (e.g., intracerebral bleeds, traumatic brain injury, stroke)

     If yes, please describe clinical rationale for continued treatment*.

☐ No

* Please attach a letter documenting additional information as applicable.

Prescribing Practitioner's Signature _____Date _____

Submit this form and medical records to:

Nebraska Medicaid Pharmacy Program Specialist
FAX: (402) 471-9103
eFAX: (402) 472-1104 or
Mail to: P.O. Box 95026
Lincoln, NE 68509