HUSKY Health Program
Amyloid Beta-Directed Monoclonal Antibodies for Alzheimer's Disease
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information				
Member ID #:		Member Name (Last, First):		DOS:
DOB:	Sex:	Primary Diagnosis Code:	HCPCS Code:	
Address:		City, State Zip:		

Initial and Reauthorization Requests - Please fill out completely.		
1. Which medication is being requested? Please check one: ○ J0175 - **KISUNLA™** (donanemab-azbt) ○ J0174 - **LEQEMBI®** (lecanemab-irmb)		
2. Does the patient have a diagnosis of early Alzheimer's disease (mild cognitive impairment due to Alzheimer's Disease [AD] or mild Alzheimer's dementia) with confirmed presence of amyloid pathology verified by PET scan or CSF testing? ***Please attach imaging/test results.***	○ Yes	○ No
3. Is treatment being prescribed by, or in consultation with, a neurologist, geriatrician, or geriatric psychiatrist?	○ Yes	○ No
4. Does the treating physician participate in the CMS national patient registry or another CMS-approved study?	○ Yes	○ No
5. Is there objective evidence of cognitive impairment at baseline documented by screening with an appropriate assessment tool, such as the Mini-Mental Status Exam (MMSE), Clinical Dementia Rating-Global Score (CDR-GS), or Montreal Cognitive Assessment (MoCA)? ***If yes, please attach results.*** Assessment tool used: _____ Score: _____	○ Yes	○ No
6. Has testing for ApoE ε4 Homozygote status been performed and were the implications of genetic test results regarding the risk of developing Amyloid-Related Imaging Abnormalities (ARIA) discussed with the patient and/or caregiver?	○ Yes	○ No
7. Has there been recent (within the last year) brain Magnetic Resonance Imaging (MRI) that demonstrates no evidence of other significant pathological findings (e.g., hemorrhages) and no evidence of other clinically significant lesions that could indicate a dementia diagnosis other than AD? ***Please attach imaging results.***	○ Yes	○ No
8. Does the patient have a bleeding disorder? a. If yes, is it adequately controlled?	○ Yes ○ Yes	○ No ○ No
9. Does the patient have any other neurologic disorders that may be contributing to cognitive impairment above and beyond that which is caused by AD?	○ Yes	○ No
10. Does the patient have contraindications to amyloid testing (e.g., PET, CSF testing) or to MRI brain scan (e.g., metallic implants, cardiac pacemaker/defibrillator)?	○ Yes	○ No
11. Has the patient been provided with information on the requirements for treatment and expected outcomes, potential side effects, risks (including the risks of ARIA), and burdens related to administration and monitoring?	○ Yes	○ No
12. For **LEQEMBI** requests only: a. Is the patient 50 years of age or older? b. Is the patient on therapeutic anticoagulation, except for aspirin at a prophylactic dose, or other antiplatelet agents at standard therapeutic doses (e.g., clopidogrel, prasugrel, ticagrelor)? c. Does the patient have a history of stroke, transient ischemic attacks, or seizures documented within the last 12 months? d. Will Leqembi be used in combination with any other amyloid beta-directed antibodies (e.g., Kisunla)? e. Will the treating physician follow all FDA requirements related to dosing, administering, and monitoring for ARIA, including use of MRI before the fifth, seventh, and 14th infusions, and as needed if the patient experiences symptoms suggestive of ARIA?	○ Yes ○ Yes ○ Yes ○ Yes ○ Yes	○ No ○ No ○ No ○ No ○ No
13. For **KISUNLA** requests only: a. Is the patient 60 years of age or older? b. Will Kisunla be used in combination with any other amyloid beta-directed antibodies (e.g., Leqembi)? c. Will the treating physician follow all FDA requirements related to dosing, administration, and monitoring for ARIA including use of MRI before the second, third, fourth, and seventh infusions, and as needed if the patient experiences symptoms suggestive of ARIA?	○ Yes ○ Yes ○ Yes	○ No ○ No ○ No
Reauthorization Requests ONLY. Please fill out completely.		
1. Is the patient continuing to benefit from treatment as evidenced by objective, validated tests used longitudinally for assessment? ***Please attach signed letter from ordering physician.***	○ Yes	○ No
2. All MRI scans performed per recommended protocol demonstrate that the patient does not show evidence of ARIA. If no, and ARIA is present: a. It is mild, and the patient is asymptomatic. b. The patient does not have unresolved moderate or severe ARIA. ***Please attach results of most recent MRI scan.***	○ Yes ○ Yes ○ Yes	○ No ○ No ○ No
3. Has the patient manifested severe symptoms (e.g., seizures, stroke-like manifestations) in the presence of ARIA?	○ Yes	○ No

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Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	
Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	Provider Specialty:
Certification Statement: This is to certify that the requested treatment is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.	
Provider Signature:	Date: