



HUSKY Health Program
KISUNLA™ (donanemab-azbt)
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. 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the patient 60 years of age or older?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is treatment being prescribed by, or in consultation with, a neurologist, geriatrician, or geriatric psychiatrist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does the treating physician participate in the CMS national patient registry or another CMS-approved study?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Assessment tool used:		Score:	
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? If yes, please attach results.		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the patient have a bleeding disorder? a. If yes, is it adequately controlled?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Has the patient had a stroke or transient ischemic attack within the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does the patient have a history of seizures?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Does the patient have uncontrolled hypertension?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Does the patient have autosomal dominant AD? a. If yes, is the mutation associated with high prevalence and burden of cerebral amyloid angiopathy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Does the patient have AD due to Down syndrome?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Does the patient have any history of immunologic disease (e.g., lupus erythematosus, rheumatoid arthritis, Crohn's disease) or systemic treatment with immunosuppressants, immunoglobulins, or monoclonal antibodies or their derivatives?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Does the patient have active cancer that interferes with the ability to comply with KISUNLA™ treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Is the patient undergoing current treatment with therapeutic anticoagulation except for aspirin at a prophylactic dose or other antiplatelet agents at standard therapeutic doses (e.g., clopidogrel, prasugrel, ticagrelor)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. 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)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Will KISUNLA™ be used in combination with any other amyloid beta-directed antibodies (e.g., LEQEMBI®)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Will the treating provider 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the patient manifested severe symptoms (e.g., seizures, stroke-like manifestations) in the presence of ARIA?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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: