Aduhelm (aducanumab-avwa)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (ALL of the following criteria must be met):

- ❑ The medication is prescribed by a board certified neurologist or geriatrician
- ❑ The patient is between the ages of 50-85 years old
- ❑ The patient has a diagnosis of Alzheimer's disease with mild dementia or mild cognitive impairment as evidenced by the following within the past 6 months:
  - ❑ Clinical Dementia Rating (CDR) global scale of ≤0.5 **AND**
  - ❑ Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score ≤ 85 **AND**
  - ❑ Mini-Mental State Examination (MMSE) score of ≥ 24
- ❑ The request includes documentation of a brain MRI within the past year without evidence of the following:
  - ❑ Acute or sub-acute hemorrhage
  - ❑ Cortical infarct
  - ❑ >1 lacunar infarct
  - ❑ Prior microhemorrhage or prior subarachnoid microhemorrhage not due to underlying structural hemorrhage
  - ❑ Greater than 4 microhemorrhages
  - ❑ Superficial siderosis

- ❑ History of diffuse white matter disease

- ❑ The request includes documentation showing presence of amyloid abnormalities as determined by positron emission tomography (PET) or lumbar puncture
- ❑ The patient has documented 3-month trial and failure of the following:
  - ❑ Cholinesterase inhibitor (e.g. donepezil, rivastigmine)
  - ❑ Memantine
- ❑ The patient has not experienced any of the following:
  - ❑ Alcohol or substance misuse in the past one year
  - ❑ Clinically significant or unstable psychiatric illness within the last 6 months
  - ❑ Contraindication to amyloid testing (e.g., PET or brain MRI)
  - ❑ History of other possible contributors to the symptoms of dementia (e.g., Huntington's Disease, HIV related cognitive impairment, frontotemporal lobar degeneration, hypothyroidism, Lewy body dementia, Parkinson's disease, prion disease, syphilis, traumatic brain injury, vitamin B12 deficiency)
  - ❑ History of significant cardiac disease (e.g., chronic heart failure, clinically significant conduction abnormalities, history of unstable angina, myocardial infarction, uncontrolled hypertension) within past one year
  - ❑ Impaired renal or liver function
  - ❑ Relevant brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities
  - ❑ Use of antiplatelet or anticoagulant medications other than prophylactic aspirin, including warfarin, DOACs, and $P2Y_{12}$ inhibitors
- ❑ The requested dose follows FDA prescribing information

Re-authorization Criteria:

- ❑ Absence of amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 4^{th}, 7^{th}, and 12^{th} infusions as determined by brain MRI
- ❑ Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤0.5, RBANS delayed memory index score ≤85, and MMSE score ≥24
- ❑ Titration up to 10 mg/kg maintenance dose

Initial Authorization: Up to six (6) months
Re-authorization: 6 months

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

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Prescriber's Signature Date