carolina complete health™

Pharmacy Prior Approval Request for Aduhelm

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Does the beneficiary have mild cognitive impairment due to Alzheimer's Disease or mild Alzheimer's Dementia? ☐ **Yes** ☐ **No**
2. Has the beneficiary received all of the tests listed below?
   a. Clinical Dementia Rating (CDR) -Global Score of 0.5 ☐ **Yes** ☐ **No**
   b. Objective evidence of cognitive impairment at screening ☐ **Yes** ☐ **No**
   c. Mini-Mental Status Exam (MMSE) score between 24 and 30 (inclusive) OR equivalent tool indicating MCI or mild dementia (NOTE: range of scores may be adjusted based on educational status of patient) ☐ **Yes** ☐ **No**
   d. Positron Emission Tomography (PET) scan is positive for amyloid beta plaque or Cerebrospinal Fluid Test (collected via lumbar puncture) is positive for amyloid ☐ **Yes** ☐ **No**
3. Is the beneficiary age 50 or older? ☐ **Yes** ☐ **No**
4. Has the beneficiary undergone testing to rule out reversible causes of dementia ☐ **Yes** ☐ **No**
5. Has the beneficiary had an assessment including a review of current medications as a cause of intellectual decline? ☐ **Yes** ☐ **No**
6. Has the beneficiary had a recent (within one year) brain MRI prior to beginning treatment? ☐ **Yes** ☐ **No**
7. Has the Prescriber has assessed and documented baseline disease severity utilizing an objective measure/tool? ☐ **Yes** ☐ **No**
8. Does the Beneficiary does NOT have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis? ☐ **Yes** ☐ **No**
9. Has the beneficiary had a failure of or inability to tolerate at least one other preferred cholinesterase inhibitor Alzheimer therapy for at least four months? ☐ **Yes** ☐ **No** Please List_____
10. Does the provider attests to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg)? ☐ **Yes** ☐ **No**
11. Does the beneficiary have hypersensitivity to any components of Aduhelm™? ☐ **Yes** ☐ **No**
12. Is Aduhelm™ being prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist? ☐ **Yes** ☐ **No**

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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/