

Request for Prior Authorization for Aduhelm (aducanumab-avwa)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Aduhelm (aducanumab-avwa) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Aduhelm (aducanumab-avwa) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **Alzheimer's disease** and the following criteria is met:

- Must be prescribed by or in consultation with a neurologist
- Must have mild cognitive impairment (MCI) or mild dementia consistent with Stage 3 or 4 Alzheimer's disease confirmed by meeting ALL of the following:
 - Clinical Dementia Rating global score (CDR-GS) of 0.5
 - Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score ≤ 85
 - Mini-Mental State Examination (MMSE) score of 24-30
- Must provide documentation of a brain MRI within the past year
- Must provide documentation of a PET scan confirming presence of amyloid pathology
- Must provide chart documentation showing that all medical or neurological conditions (other than Alzheimer's) that might be a contributing cause of the member's cognitive impairment have been ruled out.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to BOTH of the following:
 - Cholinesterase inhibitor (ie. donepezil)
 - Memantine
- Must not have any of the following:
 - Stroke, TIA, or unexplained loss of consciousness in the past year
 - Clinically significant unstable psychiatric illness in past 6 months
 - History of unstable angina, myocardial infarction, advanced chronic heart failure, or clinically significant conduction abnormalities within the past year
 - Impaired renal or liver function
 - HIV infection
 - Significant systematic illness or infection in the past 30 days
 - Relevant brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities
 - Contraindications to MRI or PET scans
 - Alcohol or substance abuse in the past year
 - Taking blood thinners (except for aspirin at a prophylactic dose or less)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months

- **Reauthorization criteria**
 - Must have mild cognitive impairment (MCI) or mild dementia consistent with Stage 3 or 4 Alzheimer's disease confirmed by ONE of the following within the past 6 months:
 - CDR-GS of 0.5 or 1.0
 - MMSE score \geq 18
 - Must not have any of the following:
 - Stroke, TIA, or unexplained loss of consciousness in the past year
 - History of unstable angina, myocardial infarction, advanced chronic heart failure, or clinically significant conduction abnormalities within the past year
 - Impaired renal or liver function
 - HIV infection
 - Relevant brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities
 - Contraindications to MRI or PET scans
 - Alcohol or substance abuse in the past year
 - Taking blood thinners (except for aspirin at a prophylactic dose or less)
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

**ADUHELM (ADUCANUMAB-AVWA)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00 am to 7:00 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Billing Information

This medication will be billed: at a pharmacy **OR** medically, JCODE: _____
Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____ ICD Code: _____
What is the disease severity? Mild Cognitive Impairment (MCI) Mild dementia Moderate dementia Severe dementia
Please provide the date administered and score of the following tests:
Mini-Mental State Examination (MMSE) Score, Date: _____ Score: _____
Clinical Dementia Rating global score (CDR-GS), Date: _____ Score: _____
Repeatable Battery for Assessment of Neuropsychological Status (RBANS), Date: _____ Score: _____
Has the member had an MRI within the past year? Yes No
Has the member had a PET scan confirming amyloid pathology? Yes No
Have all medical or neurological conditions other than Alzheimer's been ruled out? *Chart documentation is required.*
 Yes No

Please indicate if any of the following apply to the member (check all that apply):

- Stroke, TIA, or unexplained loss of consciousness in the past year
- Clinically significant unstable psychiatric illness in past 6 months
- History of unstable angina, myocardial infarction, advanced chronic heart failure, or clinically significant conduction abnormalities within the past year
- Impaired renal or liver function
- HIV infection
- Significant systematic illness or infection in the past 30 days
- Relevant brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities
- Contraindications to MRI or PET scans
- Alcohol or substance abuse in the past year
- Taking blood thinners (except for aspirin at a prophylactic dose or less)

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

**ADUHELM (ADUCANUMAB-AVWA)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2**

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PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: Height:

REAUTHORIZATION

What is the disease severity? Mild Cognitive Impairment (MCI) Mild dementia Moderate dementia Severe dementia

Please provide the most recent date administered and score of the following tests:
 Mini-Mental State Examination (MMSE) Score, Date: _____ Score: _____
 Clinical Dementia Rating global score (CDR-GS), Date: _____ Score: _____
 Repeatable Battery for Assessment of Neuropsychological Status (RBANS), Date: _____ Score: _____

- Please indicate if any of the following apply to the member (check all that apply):
- Stroke, TIA, or unexplained loss of consciousness in the past year
 - History of unstable angina, myocardial infarction, advanced chronic heart failure, or clinically significant conduction abnormalities within the past year
 - Impaired renal or liver function
 - HIV infection
 - Relevant brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities
 - Contraindications to MRI or PET scans
 - Alcohol or substance abuse in the past year
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SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date