John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

Retail Pharmacy Requests

☐ **Magellan Medicaid Administration, LLC**
For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare
Phone: 1-800-424-1664 / Fax: 1-800-424-7402

☐ **Fee-for-Service (FFS) Louisiana Legacy Medicaid**
Phone: 1-866-730-4357 / Fax: 1-866-797-2329 / www.lamedicaid.com

Requests for Medications Through Medical Benefit

☐ **Aetna Better Health of Louisiana** – Medical Benefit – Physician Administered Drugs
Phone: 855-242-0802 / Fax: 844-227-9205 / TTY: 855-242-0802, 711

☐ **AmeriHealth Caritas Louisiana**
Phone: 1-800-684-5502 / Fax: 1-855-452-9131 / www.amerihealthcaritasla.com/pharmacy/priorauth.aspx

☐ **Healthy Blue** – Medical Injectables
1-844-521-6942 (M–F 7 a.m.–7 p.m., Sat. 9 a.m.–1 p.m. CT) / Fax: 844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – Professionally Administered Drugs
Availity.com (registration required)
Phone: 1-866-461-7273 (M–F 7 a.m.–10 p.m. CT) / Fax: 1-888-447-3430 / (request form at Humana.com/medPA)

☐ **LA Healthcare Connections** – Physician Administered Medication (Buy and Bill)
Phone: 1-866-595-8133 / Fax: 1-866-925-3006

☐ **United Healthcare** – Medical Benefit
Phone: 1-888-397-8129 / Fax: 877-271-6290 / www.UHCprovider.com

Print Reset

Magellan Medicaid Administration

Louisiana Medicaid

Aducanumab-avwa (Aduhelm®) Clinical Authorization Form

Fax this form to 1-800-424-7402

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Incomplete forms will not be approved. Information contained in this form is Protected Health Information under HIPAA.

SECTION 1: SUBMISSION

Submitted to: _____

Receiver Phone: _____ Receiver Fax: _____ Date: _____

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____ Middle Initial: _____

Prescriber NPI: _____ Plan Provider #: _____ Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Office Contact Name: _____ Contact Phone: _____

SECTION 3: PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

Date of Birth: _____ Patient Phone: _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Plan Name (if different from Section 1): _____

Member #: _____ Medicaid #: _____ Plan Provider ID: _____

CCN #: _____

EPSDT Support Coordinator contact information (if applicable):

EPSDT Support Coordinator First Name: _____

EPSDT Support Coordinator Last Name: _____

EPSDT Support Coordinator Phone: _____

SECTION 4: PRESCRIPTION DRUG INFORMATION

Drug Name: **aducanumab-avwa (Aduhelm®)** Quantity: _____ Day Supply: _____

Drug Strength: ☐ 170 mg/ 1.7 mL ☐ 300 mg/ 3 mL

Patient's Name: _____

SECTION 4: PRESCRIPTION DRUG INFORMATION (CONTINUED)

Titration Dosing (Select one):

☐ 1 mg/kg/dose IV q4 weeks x 2 doses ☐ 3 mg/kg/dose IV q4 weeks x 2 doses

☐ 6 mg/kg/dose IV q4 weeks x 2 doses

Maintenance Dosing: ☐ 10 mg/kg/dose IV q4 weeks

Other: _____

1. This request is for:

   ☐ Initiation of Treatment ☐ Continuation of Treatment

SECTION 5: PATIENT CLINICAL INFORMATION

2. Does the patient have a diagnosis of Alzheimer's disease?

   ☐ Yes ☐ No

   If Yes, date diagnosed: _____

3. Specify severity of cognitive impairment / dementia:

   ☐ Mild Cognitive Impairment ☐ Mild Dementia

   ☐ Moderate Dementia ☐ Severe Dementia

4. Was the presence of beta-amyloid plaques confirmed by one of the following?

   Positron emission tomography (PET) scan:

   ☐ Yes ☐ No

   If Yes, date of test: _____ Prescriber Initials: _____

   Cerebrospinal fluid (CSF) testing:

   ☐ Yes ☐ No

   If Yes, date of test: _____ Prescriber Initials: _____

SECTION 6: FOR INITIATION OF THERAPY REQUESTS ONLY

Document objective evidence of mild cognitive impairment or mild dementia due to Alzheimer's disease below. (Both are required.)

Clinical Dementia Rating-Global Score (CDR-GS)

Score: _____ Date: _____

Mini-Mental State Exam (MMSE)

Score: _____ Date: _____

Specify tool used to document baseline disease severity. (Note: Same tool **must** be used for baseline assessment and for ongoing assessments.)

Alzheimer's Disease Assessment Scale – Cognitive Subscale (ADAS-Cog-13)

Score: _____ Date: _____

Clinical Dementia Rating – Sum of Boxes (CDR-SB)

Score: _____ Date: _____

Montreal Cognitive Assessment (MoCA)

Score: _____ Date: _____

Repeatable Battery for Assessment of Neuropsychological Status (RBANS)

Score: _____ Date: _____

Other: _____

Score: _____ Date: _____

(Name of tool and defining parameters for disease severity for this tool must be included.)

Patient's Name: _____

SECTION 6: FOR INITIATION OF THERAPY REQUESTS ONLY (CONTINUED)

5. Does the patient have any contraindication to magnetic resonance imaging (MRI)?
   ☐ Yes ☐ No
   If Yes, explain: _____
6. Most recent MRI Date: _____
7. Please initial below to confirm the results of the MRI:
   Were there any findings of localized superficial siderosis?
   ☐ Yes ☐ No Prescriber Initials: _____
   Were there findings of less than 5 brain microhemorrhages?
   ☐ Yes ☐ No Prescriber Initials: _____
   Were there findings of any brain hemorrhages > 1 cm within the past year?
   ☐ Yes ☐ No Prescriber Initials: _____
8. Is the patient currently taking blood thinners (except ≤ 81 mg aspirin)?
   ☐ Yes ☐ No
9. Is the patient ambulatory?
   ☐ Yes ☐ No
10. Has the patient had a bleeding disorder or cerebrovascular abnormalities (including, but not limited to, stroke or transient ischemic attack [TIA]) in the last 12 months?
    ☐ Yes ☐ No
11. Have other causes of cognitive impairment been ruled out (including, but not limited to, alcohol/substance abuse, frontotemporal dementia [FTD], Lewy body dementia [LBD], Parkinson's disease dementia, unstable psychiatric illness, and vascular dementia)?
    ☐ Yes ☐ No
12. Does the patient have a history of unstable angina, myocardial infarction, advanced chronic heart failure, clinically significant conduction abnormalities or unexplained loss of consciousness within 1 year of treatment initiation?
    ☐ Yes ☐ No
13. Has the patient had a seizure in the past 3 years?
    ☐ Yes ☐ No

SECTION 7 – FOR CONTINUATION OF THERAPY REQUESTS ONLY

Date of treatment initiation: _____ Number of doses since initiation: _____

Provide date of most recent MRI: _____ (See criteria for MRI recommendations.)

Note: It is recommended that practitioners use the same MRI device with the same imaging protocol for a given patient whenever possible to assist in comparing the images.

For continuation of therapy requests, current clinical symptom severity and MRI findings must be noted below (see next page).

Patient's Name: _____

SECTION 7 – FOR CONTINUATION OF THERAPY REQUESTS ONLY (CONTINUED)

ARIA-E clinical symptom severity:

☐ None ☐ Mild ☐ Moderate ☐ Severe

ARIA-E radiographic severity:

☐ None ☐ Mild ☐ Moderate ☐ Severe

ARIA-H clinical symptoms:

☐ Yes ☐ No

ARIA-H radiographic severity:

☐ None ☐ Mild ☐ Moderate ☐ Severe

14. Has the patient progressed to the moderate or severe stage of Alzheimer's disease?
    ☐ Yes ☐ No
15. Since baseline assessment, has the patient had a **positive clinical response** to treatment demonstrated by assessment with the same validated tool that was used to establish baseline disease severity?
    ☐ Yes ☐ No
16. Name of tool used to assess baseline disease severity **and** ongoing assessments:

    _____

    Date of baseline assessment: _____ Score: _____

    Date of most recent follow-up assessment: _____ Score: _____

SECTION 8 – ADDITIONAL CLINICAL INFORMATION

SECTION 9: PHARMACY INFORMATION (OPTIONAL)

Name of Dispensing Pharmacy: _____

Pharmacy NPI: _____ Pharmacy Phone: _____

Pharmacy Street Address: _____

City: _____ State: _____ Zip: _____

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Prescriber Signature: _____ **Date:** _____

(Proxy signatures are not accepted.)

Mail requests to:

Magellan Medicaid Administration, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-1664 **Fax this form to 1-800-424-7402**